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ABSTRACT

Day care is a growing service in the field of long-term care, increasing the options available to the impaired elderly. To study the development of adult day care centers in southeastern New England, and to identify the relationship of day care centers to the long term care network of services, the 11 day care centers in the catchment area of the southeastern New England Long Term Care Gerontology Center were studied (6 in Massachusetts and 5 in Rhode Island). Surveys of professional personnel and clients, and site visits were used to compare the centers in terms of physical facilities, admission criteria, participant characteristics, financial resources, staffing services and activities, and relationship with families and community activities. Results showed that all centers admit clients regardless of living conditions, although 41% of those admitted live alone. Day care had no significant effect on nursing home entry or length of stay. The population served was similar to the general elderly population rather than those at special risk. The data indicated a clear identification of day care centers as an integral part of the network of long term care services. The results suggest leadership and advocacy roles for the southeastern New England Long Term Care Gerontology Center. Appendices include letters to centers, interview questionnaires, a list of day care centers in the catchment area, and the Massachusetts Adult Day Health Manual. (JAC)

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RHODE ISLAND COLLEGE

GERONTOLOGY CENTER

Day Care as a Long-Term Care Service

Study

Dr. Gamal Zaki
Ms. Sylvia Zaki

U.S. DEPARTMENT OF EDUCATION
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Gamal Zaki--Sylvia Zaki

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TABLE OF CONTENTS

	Page
CHAPTER 1	
1. Statement of the Problem	1
2. Methodology	2
CHAPTER II	
1. Introduction	
A. The Inception of the Concept	5
B. State-Of-The-Art: U.S.A.	7
2. Case Study: Selected Day Care Centers	
A. Handmaker Jewish Geriatric Center	10
B. The Levindale Adult Day Treatment Center	18
C. Day Center for the Elderly in the Bronx	24
D. Day Care Centers: The State of California	27
CHAPTER III	
1. Definitions	
A. Day Hospital	34
B. Day Care Centers	36
C. Day Hospital vs. Day Center	37
D. Day Care as a Long-Term Care Service	41
CHAPTER IV--The Transcentury Study	53
CHAPTER V	
1. Analysis and Interpretation	
--Comparisons of the Centers	69
--Physical Facilities	70
--Criteria and Processes for Admission to Day Care Centers	70

Page

--Intake and Review Procedures 75
--Participants' General Profile 80
--General Characteristics 80
--Budget and Financial Resources 87
--Staffing 91
--Services 93
--Daily Activities 99
--Relationship with Families and Community Agencies 100

2. Reactions 101

CHAPTER VI--Conclusions and Recommendations

1. Conclusions

--Criteria and Process for Admission 104
--Quality of Services 107
--Day Care Centers and Long Term Care 108
--Links and Relations: An Identity Crisis 110

2. Recommendations 112

3. Appendices 115

4. Bibliography 116

LIST OF TABLES

		Page
Table 1:	Conceptual Distinctions Between British Day Hospital and Day Center	40
Table 2:	Geriatric Day Services	43
Table 3:	Adult Day Care Centers Selected for Trans-century Study	63
Table 4:	Summary of Degree of Impairment Criteria	74
Table 5:	Variations Among Centers re. Physical and Psychosocial Impairments Criteria	75
Table 6:	Procedures of Admission Prior to Acceptance	77
Table 7:	Procedures Upon Acceptance	78
Table 8:	Marital Status of Respondents	80
Table 9:	Educational Background of Respondents	81
Table 10:	Occupational Distribution of Respondents	81
Table 11:	Age Distribution of Sample	82
Table 12:	Living Arrangements for Respondents	83
Table 13:	Living Arrangements for Clients According to Centers	84
Table 14:	The Directors of Centers Estimation of Clients Physical Conditions	86

		Page
Table 15:	Some Aspects of Level of Functioning of Respondents	86
Table 16:	Average Attendance of Respondents per Week	87
Table 17:	Summary of Data About Centers	90
Table 18:	Staffing Patterns of Centers	92
Table 19:	Services Available to Clients at Centers	94
Table 20:	Auxiliary Services Available through Centers	95
Table 21:	Transportation Utilized	96

CHAPTER I

1. Statement of the Problem

2. Methodology

The growing nationwide interest in long-term care implies a thorough examination not only of the concept, but the wide spectrum of practices related to this essential human service. One of the most growing services in the field of long-term care is day care, mainly to increase the options available to the impaired elderly. However, since the inception of this service in the U.S.A., there has been a great deal of discussion as to the functions of day care as an integral part of the long-term network of services.

The authors have been interested in the development of day care centers in the State of Rhode Island since 1974. Through a research grant from the National Gerontological Society, one of the authors conducted a study on "Geriatric Day Care Centers in Rhode Island."(1) They have been very close to the development of the movement not only in the State of Rhode Island, but nationwide as well.

This study addresses an important area of service to the elderly. With the increasing interest in long-term care, it is essential to identify the structure and functions of day care services as an integral part of long term care. The study will be exploratory in nature, establishing the basis for a full scale study in the future.

I. Statement of the Problem

The purpose of this study is to survey the existing day care services in the catchment area of the Southeastern New England Long-Term Care Gerontology Center.

The specific research questions to be addressed are as follows:

A. What is the history of the development of the day care service in the region?

B. What population do they service?

C. What modalities in terms of structure and function are being implemented.

II. Methodology

The survey has been conducted in four stages:

A. First Stage: Survey of Literature

This entailed survey of literature for the following purposes:

a. To gain familiarity with the general theoretical frames and practices.

b. To focus on certain issues pertaining to the research question.

c. To identify the different variables bearing on the research question.

d. To identify different modalities and practices in the field of day care services.

Material about selected day care centers; development, structure and functions in the U.S.A. was reviewed by the authors.

B. Second Stage: Survey of Day Care Centers in the Catchment Area

The Catchment Area was identified and all Day Care Centers were contacted to participate in the study. Favorable responses were achieved. (Appendix 1)

C. Third Stage: Development of Data Collection Techniques

1. Interview Schedules were developed. The main questions addressed in these schedules are:

a. What are the services offered through Day Care Centers in the region?

b. What is the population being served?

c. What modalities in terms of structure and functions are being implemented?

d. How are these services funded?

e. How are these services staffed?

f. Are there any evaluative studies conducted to identify the effectiveness of these services?

g. What are the relationships between day care services and the network of long-term care services, as perceived and practiced by the staff of the selected day care agencies?

h. What are the future expectations for expansion of these services?

i. What are some of the apparent problems facing the implementation of these services?

2. The schedules were pretested in two different Centers. The schedules were modified, reviewed, and developed in the last form prior to printing. (Appendix 2)

D. Fourth Stage: Data Collection

The day care centers in the catchment area had been visited, directors were interviewed, and in some cases some clients were also interviewed.

E. Fifth Stage: Tabulation, Analysis and Interpretation

Collected data was manually tabulated, since most of the questions were open ended. Analysis and interpretation were done and a final report was written.

References

Chapter I

1) Gamal Zaki, Summer Consultation Program, Study of Day Care Centers, 1974.

CHAPTER II

1. Introduction
   - A. The Inception of the Concept
   - B. State-Of-The-Art: U.S.A.
2. Case Study: Selected Day Care Centers
   - A. Handmaker Jewish Geriatric Center
   - B. The Levindale Adult Day Treatment Center
   - C. Day Center for the Elderly in the Bronx

INTRODUCTION

(1) THE INCEPTION OF THE CONCEPT:

Occupational centers for the sub-normal, opened in 1914, were the beginning of our present concept of day care. The first da, care hospitals for psychiatric patients were introduced in the U.S.S.R. between the Wars. Psychologically troubled patients paid day care visits to mental institutions or psychiatric centers for treatment, returning to their homes each night. [1]

The concept of adult day care emerged in recent times from England where it has functioned as an alternative to institutional residency for more than two decades and is part of the British national health service. [2] Day care services for geriatric patients is believed to have started at the Crowly Road Hospital in Oxford, England in 1958. [3] In 1957 the British Ministry of Health cited the advantages of geriatric day hospitals: (1) early discharges from hospital facilities: (2) follow-up and continuation of in-patient therapy in order to prevent any further physical deterioration: (3) the possible elimination of the need for in-patient admission for certain types of patients: (4) social and emotional support of the lonely, elderly population; and (5) a means to relieve families from a twenty-four hour caretaking function. Further advantages of day hospital care are a reduction in the need for nurses (one shift instead of several) and the availability of hospital facilities to a larger population. [4]

Between 1966 and 1968, the concept of day care was expanded and eventually formalized as a means of offering the marginally impaired access to supportive health and social services without forcing them to forego residency in the community. [5]

Day care for geriatric patients with medical-nursing components is not well developed in the United States. Day care in the United States is primarily associated with psychiatric patients, as was the initial experience in the United Kingdom. However, there are several experiences with day care facilities for chronically ill aged which can be cited. Perhaps the earliest attempt at providing day care services in the United States was in Schenectady, New York where in 1958 a three year project on a day hospital rehabilitation program was instituted. The project was an outgrowth of an extensive program of out-patient services offered by the Schenectady City Hospital. One recommendation coming from the Schenectady project was that a day hospital program be connected to an in-patient rehabilitation facility since fifty percent of the patients cared for required in-patient admisstion before being transferred to the day hospital. Pre-admission assessment was emphasized as being an important component of the program. A further recommendation was that there be adequate follow up for day care patients since there was evidence of patient decline after day care discharge.[6]

(2) STATE-OF-THE ART: U.S.A.

A survey of the historical development of day care centers in the U.S. reflects a movement of acceptance of the concept and its practices as an integral part of the long term care continuum of services. Robins indicates only 10 years ago federal support was first provided for four experimental programs. Four years later, in 1974, the federal government provided support for a state-of-the art paper of adult day care. There were fewer than 15 locations from which programs could be selected for study. At about the same time, the National Center for Health Services Research of HEW initiated a series of demonstration contracts at four sites for development and evaluation of a particular model of day care which for convenience at the time was called the "health model."

In 1977, a Directory of Adult Day Care Programs listed approximately 200 programs. A year later, a revised directory contained 275 programs. This is a sharp contract to the updated directory published in November, 1980 containing more than 600 programs. However, some programs were missed in the 1978 listing, and thus the true growth rate of adult day care programs would be at a somewhat lesser rate. Nevertheless, the jump from 15 programs in 1974 to 600 plus programs serving approximately 13,500 persons (with the number constantly increasing) is impressive. Adult day care is being accepted and utilized as a valuable modality in the continuum of long term care services.

Funding Sources

Policy makers, planners and programmers unanimously agree that third-party reimbursement for adult day care is vital to make the service universally available. Currently, reimbursement is available to certain programs, in certain states, but with little assurance as a base for program planning.

There is no Medicare coverage for adult day care as an entitlement. Through a special waiver, it is currently being provided in an experimental program, On Lok in San Francisco. This is part of a study of a total package of health services for the elderly including a Health Maintenance Organization. In a few restorative day care programs located in Medicare-certified facilities, individual services prescribed by physicians may be reimbursed by Medicare for those who carry Part B insurance.

Coverage for adult day care by commercial insurance carriers appears to hold promise. In isolated cases, commercial insurance policies cover the cost of adult day care. Some of the unions are thinking about including this in their health coverage.

New York was the first state to utilize Medicaid reimbursement for adult day care, starting with its first program in 1970. New York currently provides reimbursement for this service in 23 programs.

In April 1973, a notice was issued by the Medicaid Program informing the states that Medicaid reimbursement could be provided for adult day care if the state elected to make it a part of its state plan.

A year later, California provided reimbursement for this service through Medicaid, and now has 13 programs authorized to do so.

In 1975, Massachusetts inaugurated its first program through Medicaid, and now leads the nation with 47 programs.

Georgia followed in 1976, and now has 10 programs; New Jersey started in 1977 and now has 8 programs; the State of Washington began its activity in 1978 and has 9 program. Maryland and Kansas authorized reimbursement for adult day care in 1980, and now have 2 and 6

programs respectively.

All of these states plan to expand Medicaid reimbursement for this service; other states are making efforts to incorporate coverage for adult day care.

Title XX, the Social Services Amendment to the Social Security Act, permits the states, at their option, to use these funds for adult day care. This has led the way to accelerated growth of programs throughout the nation. Currently 40 states provide such support for 297 programs. The most active state in this respect is Alabama with 38 programs. States with between 10 and 20 programs are North Carolina, Texas, New Jersey, Illinois, Mississippi, Tennessee, Ohio, Maryland, and Pennsylvania.

Other funding sources for adult day care include Title III of the Older Americans Act, Area Agencies on Aging, philanthropic sources revenue sharing, mental health departments, and United Way. Participant payment, sometimes on a sliding scale, is an important financial resource of many programs.[7]

3. Case Study: Selected Day Care Centers

A review of the historical development, structure and functions of some selected day care centers programs will be helpful in achieving the objectives of our study. These centers purposefully selected because of their long history and the variations in their structures and functions.

A. Handmaker Jewish Geriatric Center

(1). History

The Handmaker Jewish Nursing Home in Tucson has demonstrated a new, successful role for the long-term care instutution by extending its services for non-resident programs to the entire community. A brief review of its history will set the background for the development of these services. The Handmaker Home started 17 years ago when Tucson had a total population of 250,000 with 6,000 to 7,000 Jews. Many came to Tucson because of health problems. Because the Jewish Community was not wealthy it became apparent that support was needed from the federal government in the form of Hill-Burton Funds in order to build a Jewish Nursing Home. The Board of the Home unterstood and accepted the commitment to serve older people who were not Jewish. It became the tradition, then, from its inception, to serve the Jewish Community primarily and in addition, provide service to the non-Jew. At the same time, it was decided to adhere to traditional Judaism in the Home with Jewish dietary laws observed, all Holidays celebrated, and Orthodox Services conducted. Special efforts were made to assure that the service of the Home would reflect the goals and aspirations of the Jewish Community and provide a program in which its members could be comfortably served. The Home now has 110 residents, 15 apartments, and a community day-care program serving 200 people.

The Handmaker Jewish Geriatric Center has offered adult day care services to physically and mentally impaired persons since 1967. The first Senior Health Improvement Program (S.H.I.P.) was begun as a response to a woman's need for daily care so that her husband could return to work. Her physical condition did not requite instututionalization, but neither could she be left at home alone. Recognizing this gap in service, Handmaker staff responded by developing a therapy and activity program at the nursing facility as an alternative to institutionalization.

During the first three years of operation, the program was funded under a demonstration grant by the Committee on Economic Opportunity. An additional center was established on the west side of Tucson in space donated by St. Mary's Hospital and Health Center. The number of clients increased to a daily capacity of 20, and transportation for both services was furnished by one lift equipped van from Handmaker Jewish Geriatric Center.

Model Cities became the funding source for the program in 1970, but the real increase in program size began in 1972 when the Model Cities' money was augmented by Title III of the Older Americans Act and a National Institute for Mental Health grant. Between the period of October 1972 and September 1974, four additional centers were opened: three in hospitals and one in a nursing home. The space provided by these health care facilities was donated, and services such as meals and physical therapy were purchased. The centers had a neighborhood orientation, and were placed around the community in such a way that participants spent limited time in transportation.

During this period, anywhere from 90 to 125 participants were served on any one day, with a weekly enrollment of 235 and a yearly caseload of 400 separate individuals. All transportation was provided by the City of Tucson, which had by this time developed an extensive service to the elderly and handicapped using 30 mini-vans, twelve of which were equipped with wheelchair lifts. Approximately fifty percent of the participants were put in touch with the program by facilitators who provided intake and counseling services to the elderly of Pima County. This group of social service workers was also funded by Area-wide Model Project Funds, and contributed to the large program enrollment. S.H.I.P. had also established a sufficient local reputation so that an equal number of referrals were received from private individuals, physicians, and other social and health agencies. The facilitators, the transportation system, and the reputation of the hospitals were all strong contributory factors to the success of the adult day care programs.

At the end of fiscal year 1974-1975, the Model Cities' funding and Title III monies expired, and the program was in imminent danger of closing. Much work had been done in Pima County to gain access to Title XX dollars, which represented an appropriate new source of funds. The delay in establishing mechanisms for tunneling the money through the State to local contractors necessitated an appeal to the local press. Program staff, along with participants and their families, made such an effective appeal through the media that the necessary contracts were signed and in effect in time to keep the operation going.

1974-1975 also began a transition period for the Senior Health Improvement Programs. The hospitals which were providing the space gratis found themselves in a cost and space squeeze, and began to ask the program to find other locations. The receipt of Title XX monies necessitated the establishment of regulations concerning the physical specifications of adult day care facilities, and much of the donated space did not meet these standards. In addition, it was obvious to program staff that development of the program was becoming more dependent on locating center sites that would be reserved exclusively for adult day care use. Philosophically there are many differing opinions on the preferable locations for adult day care centers, but S.H.I.P. has a major emphasis on the phycho-social needs of participants even though it provides many medical services. The move from health care locations to free-standing sites, although inconvenient, was interpreted as positive in down playing identification with illness and medical services. The program was also developing a client population that was increasingly more physically and emotionally in need, and centers with special equipment and facilities were badly needed. Staff knowledge needed to be developed and broadened in order to equip them with the information needed to handle individuals with complicated and demanding physical and emotional problems. The development and increase in the sophistication of both staff and facilities began late in 1975 and continues today.

The spring of 1979 saw the dedication and opening of the Florence and Edward Watz Adult day Care Building, a center constructed specifically for elderly and handicapped participants in the S.H.I.P. Program. It's 5,000 square feet of space accommodates up to 70 people per day, with a special unit for the severely disoriented which can be made separate or a part of the larger center by the use of an accordian-type door.

Early in 1977, Handmaker Jewish Geriatric Center was presented with the challenge of developing a program for severly physically disabled adults between the ages of 18 and 59. Recognizing the lack of much information about this client group, an advisory committee of disabled professionals was organized to help develop program content. The work of this group produced the Disabled Adult Improvement Program (D.A.I.P.) which opened its doors in May of 1977. It serves adults disabled by trauma, rheumatoid arthritis, cerebral palsey, multiple scherosis, and other catastrophic diseases. The program provides education and training in independent living skills as well as socialization and peer support to help its clients become active and participatory members of the community. Space for the Disabled Adult Improvement Program is leased in a large business park which offers several advantages, not the least of which is that our younger clients have a "separate" identity from the aging, more chronically ill participants of S.H.I.P. This seems to be an important and healthy delineation for both client populations.

(2) Present Operation

The Senior Health Improvement Programs and the Disabled Adult Improvement Program presently serve approximately 450 people a year in three centers. The major facility is on the Handmaker campus; the other two are strategically located throughout the community. The program has a maximum static capacity of 120 individuals with a weekly attendance of approximately 250 people. Centers are open Monday through Friday; most participants spend 6 hours daily in the center, though average attendance is 3 days per week. Ninety percent of the clientele are transported in vans that are specifically equipped to handle ambulatory and handicapped people.

Comprehensive programming accommodates the rehabilitation and maintenance needs of participants as assessed by their private physicians and program staff. Available services include health monitoring and education; nursing; social services; physical, speech, and occupational therapy; training in activities of daily living; educational and intellectual activities; arts and crafts; recreational and leisure activities; field trips; nutritional guidance; and individual and group activities. A nutritious lunch and snacks are provided.

The Programs employ 30 persons, with the administrative staff (Director, bookkeeper and clerical personnel) based at Handmaker. The health therapists are also based at Handmaker and consult at the centers as needed. The staff at each center includes a center coordinator, (on-site supervisor), a nurse, center aides, and a master's level social worker or counselor.

Any agency or individual can refer to the program, although most referrals come from Title XX case managers. If a client is eligible under Title XX income guidelines, there is no fee for services. Approximately 10% of the adult day care clients pay either the full daily charge or an adjusted fee with the help of funding provided by United Way - Tucson.

General Information for Participants and Families

Purpose of Adult Day Care

Adult Day Care/Day Health programs are for the benefit of disabled and/or frail elderly people who are experiencing a deterioration in their health and are to some degree isolated. The purpose of the treatment program is to maintain and improve the individual's total health, so that he can remain a functioning member of the community. The treatment methods include education, counseling, health therapies, leisure and recreational activities, health monitoring, nutrition and nutrition counseling, field trips, and socialization with peers. The individual will be encouraged to be as independent as he can be; unnecessary dependency on center staff will be discouraged.

Family Involvement

Family members are encouraged to become involved in the center program and in their relatives' experience at the center. Staff, the participant, and the family should work together towards developing a full understanding of the needs of the participants, and all should agree on how these needs can be best responded to - both at home and in the center. All staff, including the professional social service worker who performs the initial visit, are prepared to help the family with any problems they may have, or to provide information on aging that could be helpful.

Methods of Payment

The cost of a day of care at S.H.I.P. or D.A.I.P. is $18.00. Available at additional cost are physical and speech therapy as prescribed by a physician. S.H.I.P. does bill Medicare for therapies provided it such coverage is available.

The main funding source is Title XX as administered through Pima County Department of Improved Adult Living. Eligibility for coverage under the Title XX program is ascertained by contacting a Case Manager at one of the three Family Service Agencies (Catholic Community Services, Jewish Family Service, Family Counseling Agency). Income in excess of the Title XX eligibility levels means that the client would have to pay the full cost of service. If you choose to pay privately, billing for service is done monthly. A grant from United Way - Tucson allows for a sliding fee scale if full payment is not feasible. This can be discussed with the Center social worker.

Transpotation

Public transportation to the center located in the participant's neighborhood is usually available. Program staff will arrange this after the applicant has been accepted into the program. This transportation, provided by the City of Tucson Department of Special Needs and Handi-Car, Inc., will call at the door and will honk twice to indicate that the participant should come to the bus. Buses are

equipped with lifts and can accommodate wheelchairs. The cost of transportation depends on the individual's income. You will need to apply for a special bus pass.

If the participant is not ready to be picked up, the driver cannot wait past 2 or 3 minutes. Failure to meet the bus several concurrent times is justification for loss of transportation privileges. Some very risky medical conditions may make it impossible to transport an individual.

Please report any complaints about the transportation to the center coordinator. Transportation to a center outside the participant's neighborhood cannot be provided by Special Needs, but the individual may attend other centers if the family provides transportation.

Family Responsibilities

Program staff, in order to fulfill their responsibilities owards their clientele, must know where a family member is in case of emergency. The family must agree to the program's emergency procedures and be available if the participant requires immediate attention. Program staff will generally transport, by whatever means necessary, a participant to the nearest emergency medical room if the center nurse feels the situation requires this action.

The program cannot accept into a center an individual who has any signs of communicable disease. A participant who is will or feeling badly should not be sent to the center on that particular day. The program also does not accept individuals who, after a trial period, do not want to come to the center.

Hours of operation depend upon the particular center the participant attends and whether public transportation is used. All centers are open 8 hours a day, but the scheduling of transportation is such that the participant is usually in the center for 5½ to 6 hours. Beds for napping are available, but any participant who needs to sleep

for a long period of time several days in succession should not be sent to the center until the cause of the condition is diagnosed.

The lunch program can accommodate special diets, but staff cannot force the individual participant to adhere to a prescribed diet. Staff will remind the participant of any diet restrictions, but will not absolutely deny the individual foods if he demands them.

This same phiolosophy holds true for activities that the participant may do that are felt to be harmful by family or physician. Staff will try their best to help the participant to realize that certain activities are harmful to their health, but will not take the responsibility for controlling the participant's behavior. Program philosophy states that the participant, within certain reasonable limitations defined by mental capacity and emotional state, has the right to make decisions about his life, and that the process of making decisions maintains and improves anyone's intellectual skills.

Families may always contact personnel for information about the participant.

Funding Sources

Funds for the Adult Day Care programs are received through the Arizona Department of Economic Security from Title XX of the Social Security Act.

Compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973

Handmaker Jewish Geriatric Center, operating the Senior Health Improvement Programs and the Disabled Adult Improvement Program, does not discriminate in either employment or provision of services on the basis of color, race, national origin, sex, religion or handicap. Complaint procedures and/or rights of beneficiaries are the responsibility of the Assistant Director of Handmaker Jewish Geriatric Center. Concerns about Title VI Section 504 requirements should be addressed to this E.E.O. representative.

B. The Levindale Adult Day Treatment Center

The Levindale Adult Day Treatment Center located in Baltimore, Maryland, represents one type of day care program. While some of its features and experiences are obviously unique, much is also generic and applicable to other day care programs. The Levindale day care program officially began operation in July 1970 as an experimental program funded through a three year grant awarded to the 273-bed Levindale Hebrew Geriatric Center and Hospital by the Maryland State Commission on Aging. While it was one of the first health-related day care centers in the United States, it was preceded by at least three day care programs within the continental United States: Handmaker Center, Tucson, Arizona (1967); Neshaminy Manor Day Care Program, Doylestown, Pennsylvania (1967); and Saint Otto's Day Care Program, Little Falls, Minnesota (1969). Of the four research and demonstration projects funded by MSA/AOA in 1972, Levindale was the only center that had been operating prior to receiving the federal grant. After surveying the community, it was determined that the need for such a service did in fact exist, and after obtaining consultation from community health and social service planners and practitioners, the Levindale geriatric day care center opened with the following service objectives: (a) to provide socialization experience to physically and emotionally disabled older people; (b) to help maintain disabled older people in their own homes and communities; (c) to provide an integrated professional service to disabled people living in the community; (d) to preclude the institutionalization of disabled people by providing services through a day care center; and (e) to provide support and relieve the burden of families who care for their older disabled relative. The planning of the center, the conceptualization, and the actual processes that gave birth to the program can be traced back to the mid-1950's when the institution began to change the scope of service to provide more than the traditional old age home functions. In 1954 Levindale received Chronic Hospital accreditation, and by the late 1960's it began to increase its function as a chronic disease hospital. This shift in emphasis created a reduction in the availability of beds for applicants whose major service needs were custodial or protective care,

but this type of person continued to come to Levindale in search of service. The continued demand for some type of service provision for this group appeared to have been one important reason for Levindale's pursuance of the concept of day care.

The Levindale program has been used as a model in the inception of the new day care programs for the elderly because of its success. The original concept was that each of the Day Care participants would be assigned to a section of Levindale whose residents were similar in health to that of the participants. It was agreed that Levindale would provide all services with the exception of medical for the participants in this program. In many ways, this program is very similar to the concept of a day hospital or a treatment center. It was agreed that the name of Day Care Center would be used to emphasize the quality of providing a socializing experience for the participants.

One of the reasons Levindale is used as a model is because they have the capacity to offer psychological, social and medical care, which is considered the ideal. Currently the center is serving 36 aged persons per day, the majority of whom attend 5 days per week. Approximately 80% of the participants are certified for institutional care according to the scheme used by the State of Maryland for determining eligibility for Medical Assistance Admission. Policies have been structured to admit individuals with a combination of physical, mental, and/or social limitations. Typically, the Levindale client is inappropriately served by a senior citizen center because he or she requires a more structured environment with more emphasis on ongoing physical maintenance. On the other hand, institutional placement is inappropriate because the elderly person and/or his family does not want this arrangement.

The Levindale Center follows the HEW model (or vice versa!). The first Executive Director of the Center, Abraham Kostik, in his report, "A Day Care Program For the Physically and Emotionally Disabled", June, 1971, indicated how the program failed due to the integration of both programs, day care, and nursing home and hospital. According to the original plan, "...the staff assumed that each of the Day Care participants could be assigned to staff on the floor of the

institution (Geriatric Center and Hospital) which most closely correspond to their particular physical, emotional and social needs." The program started July 1970 with only 8 participants. In May 1971, there were 25 participants in the program, out of which 17 left the program. "The experience showed that neither the regular staff nor the patients and residents easily accepted the Day Care participants. They regarded the Day Care clientele as outsiders... The regular staff resented the additional responsibility... Some of the residents of Levindale were made uncomfortable by the Day Care program. It was difficult for many of the Levindale residents to accept the fact that people who had similar disabilities were able to live at home. It became clear that the Day Care participants were much more outgoing, aggressive, and asserted themselves." Immediate changes were implemented so the program might survive. The first main change was to separate the Day Center from the Geriatric Center and Hospital in terms of programs and services, which promoted a sense of identity to the Center. The second main change was moving the implementation of the concept closer to psychosocial rather than health care. Some quotations from the report support this statement:

"Experience has shown that this concept was superior to the original concept. The Day Care participants became a social group. They interacted with each other and planned for themselves."

"In planning the program of Day Care Services, the social worker felt that the participant and his family should be actively involved in the program. If the program was to respect the individuality of the Day Care participants, he should be involved in plans for himself. He should be given the opportunity to express his opinion and institute a mechanism for change."

The program also recognized that it gives a service to families as well as participant... It would, therefore, be important that the family be involved in the program."

"To implement this program, the Social Worker and the Nurse Coordinator planned group meetings of the Day Care participants. These

meetings were related to planning for themselves, particularly in the area of recreation... They developed a social cohesiveness and had a sense of being a group... In meeting with the Social Worker, the group...stimulated each other and ventilated their feelings. They had a sense of self-determination... The group meetings heightened the sense of group identification."

"The group meetings with the families were developed by the social worker. They were specifically around the interpersonal relationship with their parents."

"In the 9 months experience, the staff has also reconfirmed the principle of precluding medical service by Levindale for the Day Care participants. The personal physician of each of the participants is involved in planning for his patient... There is an ongoing contact between the physician and the nurse coordinator. She will administer medication, she will give special treatment."

"The role of the social worker was originally conceived as processing applications, working with the applicant and family and recruitment. It has been extended to consultation to the Day Care staff, to direct work with the Day Care participants; he has to plan programs, and group meetings with both the participants and their families."

According to Ms. Charlotte Eliopoulos, Vice President of Nursing at the Levindale Hebrew Geriatric Center and Hospital, in her comments to the authors dated November 18, 1981 some changes have occured. These changes can be summarized as follows:

1. Approximately 80% of the participants are certified for institutional care not one-third as previously quoted from Rathbone-McCuan. Approximately 60% are afflicted by Alzheimer's disease and severe mental impairment. The remainder have significant functional impairments.

2. There is more focus on health/medical dimensions.

3. The group meeting with the families are now conducted monthly.

4. In-house medical consultation is now available to clients.

In addition, these changes have taken place at the Center:

1. The population has shifted toward a more dependent, disabled one. More personal care activities (e.g., bathing) are performed at the Center.

2. The number of participants with mental impairments has increased and this appears to be the trend. Some of our participants have been denied nursing home admission due to their confusional status, however, we continue to maintain them in the Center.

3. Our daily census has increased to 36. Our total case-load is 69.

4. Approximately 25% of our participants are discharged to a nursing home and another 25% to a less intense service during the course of a year. The remaining 50% stay in the program.

5. The program is now administered under the direction of the Vice President for Nursing with a R.N. as the program director. Other staff include full time social worker, activities director, aide, orderly, secretary and part-time LPN. A Levindale physician now provides regular consultation to the program.

6. A pilot project is now being conducted whereby 6 day care participants are taken to one of the nursing home units and combined with 6 in-house residents for structured activities. Thus far it seems to be working and the participants have accepted it. We sense some functional

improvement in those who are participating and some change in staff's attitude toward and care of patients. The project is still in an early stage, so time will tell the full impact.

C. Day Center for the Elderly in the Northwest Bronx

The Day Center for the Elderly is a support program for the frail elderly. It operates under the auspices of Montefiore Hospital and Medical Center in collaboration with the Mosholu-Montefiore Community Center of the Associated YM-YWHA's of Greater N.Y. The Day Center is an individualized program of medical monitoring and therapeutic social activity for older adults who require daytime supervision because of physical, mental, social or emotional problems. The program is designed to help the frail elderly maintain themselves in their homes and in their community.

The Program

- provides nursing supervision and medical back-up services through Montefiore Hospital and Medical Center
- provides occupational therapy, home assessment and equipment recommendations for activities of daily living.
- coordinates on-going services provided by nurses, physicians, and agencies involved in the care of the member.
- arranges consultation with the staff physician and psychiatrist when needed.
- provides a complete range of supportive services and therapeutic activities including daily exercise, discussion groups, films, music, crafts, special events and trips.
- evaluates members for therapeutic groups which are led by nurses, occupational therapist and social workers.
- provides full range of social work services.
- provides hot, kosher lunches.
- provides door to door transportation throughout the Bronx. Ambulette service is available if medically indicated.
- assists families in the development and maintenance of an appropriate plan of care for the members.

Who is Eligible?

These eligibility criteria are meant to serve as guidelines. A prospective participant must:

- be 60 years of age or over. People under 60 considered on an individual basis.
- be capable of responding to a schedule of transportation.
- be continent and able to handle his/her personal hygiene needs with minimal assistance.
- be able to feed him or herself.
- be disabled physically, socially or emotionally to a degree which would prevent his or her participation in a typical program for the elderly.
- all participants must have a medical evaluation before being accepted into the program and then receive ongoing medical care either from a private physician or through a clinic. For those applicants without prior medical care, assistance can be offered in locating these services.
- have stable home living arrangements at night and weekends.

Any applicant who has had psychological difficulties must have appropriate supportive services in conjunction with admission to the program. These applicants must also be capable of participation with others in an active group setting. Those applicants who are found to be confused to the degree that they are unable to remain within the confines of the program, wander, or create a dangerous situation cannot be accepted into the program.

The Schedule

The Day Center operates Monday through Friday, between the hours of 9 am and 5 pm. The members' time in the program averages five hours per day from 10 am to 3 pm, with each participant maintaining an individualized schedule dependent on need

and ranging from one to five days each week.

The Staff

The program is directed by a professional certified social worker. The DCE staff works as a close interdisciplinary team that includes two registered nurses, a registered occupational therapist, two social workers, and a consulting part-time physician and a psychiatrist from the staff of Montefiore Hospital.

The Fee

The program is certified for medicaid reimbursement. There is a set fee for those not eligible for medicaid. Fees and payment mechanisms can be discussed in a confidential interview.

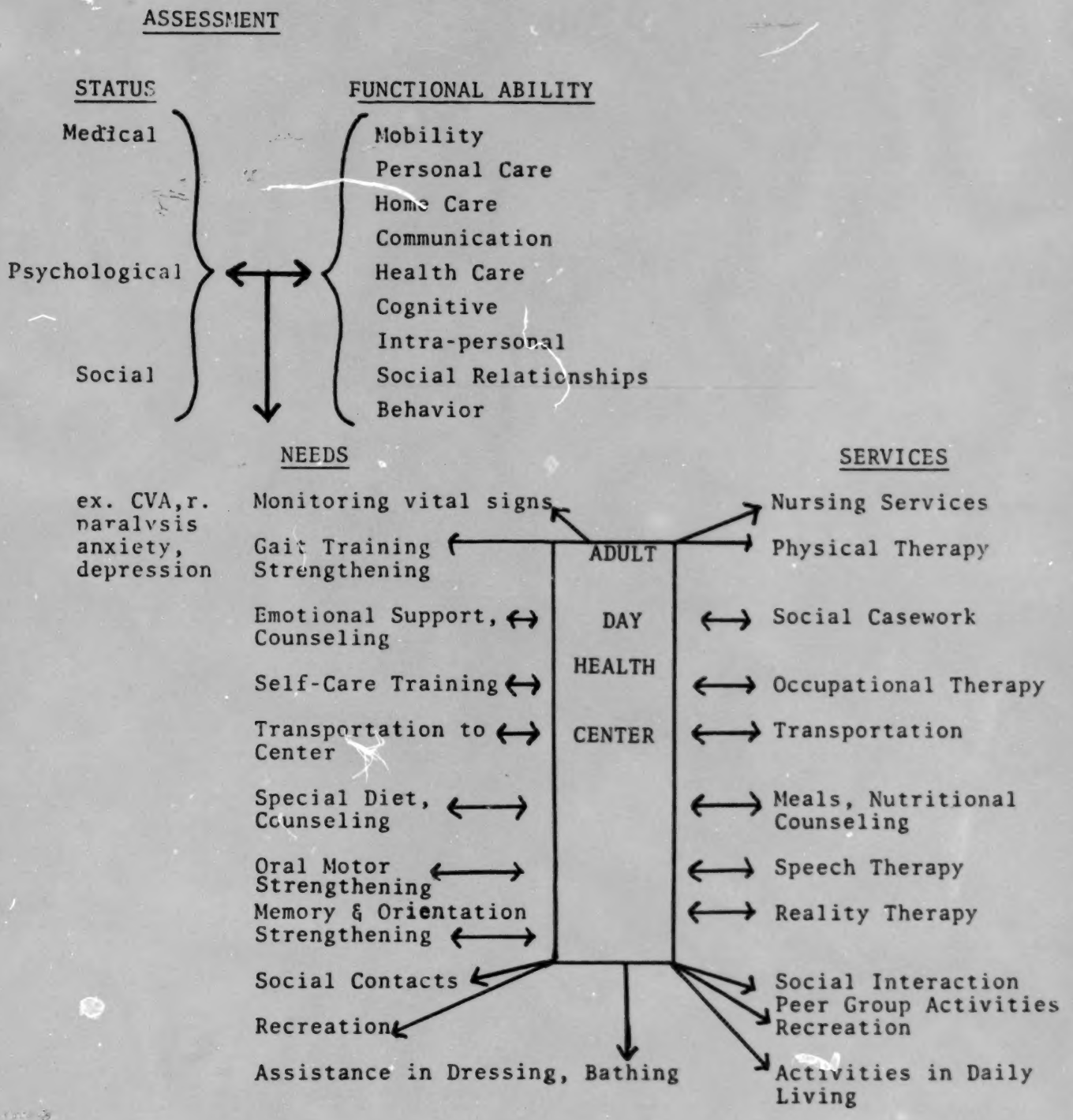
Day Care Centers

The State of California

The State of California has developed a set of regulations governing the establishment of Adult Day Health Centers through the law (AB 1611). The following is a brief review of the program.

Objectives of Adult Day Health Centers:

1. To promote or maintain independence.
2. To rehabilitate the participant to the maximum extent possible.
3. To maintain the participant in the community as long as it is medically, socially and economically feasible.
4. To prevent inappropriate or premature institutionalization.



ADULT DAY HEALTH CARE - an organized day program of therapeutic, social and health services which a Center provides to elderly persons or other persons with physical or mental impairments for the purpose of restoring or maintaining optional capacity for self-care.

Program Description

Adult Day Health Care is an organized day program of therapeutic social and health activities and services provided to elderly persons (55 and over) with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care. The program also includes other persons who are chronically ill or impaired and who would benefit from adult day health care. It is an alternative to institutionalization in long-term care facilities, when 24-hour skilled nursing care is not medically necessary or viewed as desirable by the recipient or his family.

The program is administered by the Adult Day Health Care Section which is part of the Office of Long Term Care and Aging in the Department of Health Services. Funding for the program comes from Medi-Cal. Services offered in the program are for Medi-Cal eligibles and private paying participants.

Funding is available only to cities, counties or non-profit organizations for this purpose. In order to be eligible for Medi-Cal funds under this program, the applicant agency must be included in a State-approved County Plan for Adult Day Care and then must be both certified as a Medi-Cal provider and licenses as an Adult Day Health Care provider.

Services offered in the program must be designed to meet the needs of the individual participant. The range of services provided by each Adult Day Health Care Center may vary to some degree. A combination of some of all of the services listed below should be provided.

1. Emergency services - Instructions for dealing with emergency situations must be established in writing. Such instructions must include the name and telephone number of a physician

on call, written arrangements with a nearby hospital for inpatient and emergency room service, and provision for ambulance transportation.

2. Rehabilitative services - Rehabilitative services must include physical therapy, occupational therapy and speech therapy services which are provided by the day care program directly designed to improve or maintain ability for independent functioning.

3. Medical services supervised by a physician which emphasize prevention, treatment, rehabilitation and continuity of care and also provide for maintenance of adequate medical records.

4. Nursing services rendered by professional nursing staff who periodically evaluate the particular nuring needs of each patient and provide the care and treatment that is indicated.

5. Diagnostic services in addition to initial screening including clinical laboratory, x-ray and other diagnostic services.

STEPS IN IMPLEMENTING AB 1611

1. Resolution by Board of supervisors declaring intent to form an Adult Day Health Care Planning Council: public hearing set. Notice published.

2. Public hearing on membership on Council (proposed slate may be presented for comment).

3. Board of Supervisors appoints Council and sends material to State. (Board may delegate staffwork and Council responsibility to other agency. Seniors appointed to another agency as senior representatives may be the senior representatives on this Council).

4. Council meets and determines if Adult Day Health Care is needed.

   a. Where is it needed?

      Identify target areas:

      percentage over 65 years of age
      percentage SSI/SSP
      percentage minority

   b. How many centers needed?

      Identify service area, need, accessibility

   c. What other services are available in the service area?

   d. How can they be coordinated with the Adult Day Health Care, particularly nutrition and transportation?

   e. Devise priority system-rank service areas.

   f. Develop 5-year implementation plan.

   g. Recommend and rank potential providers.

   h. Hold three public hearings on plan.

   i. Submit plan to Board for approval.

   j. Mail to State Department of Health Services.

5. Providers may now apply for license and certification to the Department of Health Services.

6. County Council will review applications and recommend to the Department of Health Services Review Committee.

7. State Department of Health Services will hold public hearings on applications in county of center.

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Chapter II

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CHAPTER III

1. Definitions

   A. Day Hospital

   B. Day Care Centers

If the day care concept were simple, so that its intended outcomes could be expressed by a unitary measure, and if the measurement of health were highly developed so that there was agreement on a definition of functioning levels there might be little doubt about how to define and to account for what geriatric day-care is attempting to accomplish. The various programs that are operating, however, are designed to achieve numerous goals. They include: (1) reducing institutionalization, (2) improving clients' life satisfaction, (3) improving clients' mental and physical functioning, (4) increasing independence, and (5) reducing health care costs. These are not the only goals espoused by day-care programs; improving family relations, and improving client/family social and economic functioning are other examples drawn from a long list. 14

There is confusion in the field, however, over the differences between day care and day hospitals. Day care and day hospital programs described during the early 1970's were likely to include psychiatric and non-psychiatric care and treatment goals and the terms day hospital and adult day care were used without distinction. 15 An attempt will be made to clarify this issue.

1. Day Hospital

Lorenze, et.al., define the day hospital as; "...model for providing health and supportive services to patients. It is operated by and as part of a general or special hospital for patients who come to the program, one or more times per week, spend a major portion of the day at the day hospital and return home to spend the night. 16

Padula offers us a similar though elaborate definition. "Day hospital is primarily a health related program for the disabled or ill aged person who requires treatment either following hospitalization, or instead of admission to 24 hours in-patient

care in a hospital or nursing home. Common reasons for referral to day hospitals serving the physically ill are physical restoration or maintenance of function for stroke and arthritis patients, change of sugical dressings, and other skilled nursing procedures. Regarding the origin of day hospitals, Padula indicates that they branch out of hospitals or at least skilled nursing homes with close ties to hospitals because of the program's reliance on health services and equipment.

She also differentiates between day hospitals and psychiatric day hospitals. The latter primarily serves the mentally ill person suffering from depression, confusion, anxiety or outbursts of temper and usually doen not accept those who also require treatment of physical ills. 17

The main thrust of day hospitals is physical rather than psychological or social except in the case of psychiatric day hospitals.

The purposes of geriatric day hospitals include: (1) earlier discharge of in-patients to the community, hastening their return to fuller function and reducing the number of beds required; (2) more successful discharge to the community, reducing the number of readmissions; and (3) maintaining frail elderly people in the community who need rehabilitative and other medical services on more than the usual out-patient basis. Another purpose is best stated in the words of Brocklehurst (1970): "The day hospital adds lustre to the geriatric department and...is a morale-booster for the whole service. By its outward-looking sense of hope, optimism and reablement, it provides a therapeutic atmosphere that bubbles over into the rest of the geriatric department. It allows doctors, nurses and therapists to accompany their patients back into the community and see the processes of rehabilitation completed. 18

Pathy thinks of the day unit as a ward where patients are given sleeping-out passes. However, there seems to be no

consensus among physicians as to what is the proper function of a geriatric day hospital, and as a result these units vary from little more than a social day centre or adult cache to an extended out-patient department. Many factors seem to influence policy-population density and its propinquity to the hospital; the personal views of the physician on what should be the functions of a day hospital; the availability of other hospital services and staff to a department of geriatrics; and the quality and quantity of community services. 19

2. Day Care Centers

Although geriatric day care centers are beginning to expand throughout the United States, there is much ambiguity about both their structure and function. A variety of definitions emerging from research and demonstration projects, technical assistance manuscripts, and federal and state guidelines have been applied to the concept. The following three definitions have been considered by Levindale:

(1) Geriatric day care provides a variety and combination of individualized medical, nursing, social and recreational services to aged persons who suffer from a degree of physical and/or psychological disability severe enough to make them potential candidates for institutional care. Despite these conditions, they attend the program during the day and return home at night to their place of residency in the community. 20

(2) This is primarily a social program for frail, moderately handicapped, or slightly confused older persons who need care during the day for some part of the week. Some live alone and cannot completely care for themselves. Others seek day care services to relieve their families of the total responsibility of their care so that they may continue to live at home. Participants may continue in the program as long as they or their families wish and as long as no health risk is involved. The day care center

program should ensure a pleasant and safe environment, supervision, activities, rest periods, and at least one nutritional meal daily. Although the staff does not provide health services as such, it should at least have First Aid Training and explicit arrangements should be made with both a physician and a hospital in case of accidents or medical emergencies. 21

(3) Day care is a program of services provided under health leadership in an ambulatory care setting for adults who do not require 24-hour institutional care and yet due to physical and/or mental impairment are not capable of full-time independent living. Participants are referred to the program by their attending physician or by some other appropriate source such as an institutional discharge planning program, a social service agency, etc. The essential elements of a day care program are directed toward meeting the health maintenance and restoration needs of participants. However, there are socialization elements in the program, which, by overcoming the isolation that is so often associated with illness in the aged and disabled, are considered vital for the purposes of fostering and maintaining the maximum possible state of health and well-being. 22

Day Hospital vs. Day Center

Rathbone-McCuan provides us with an adequate discussion of the differences between both. The distinction made between the day hospital and day center is relevant to current debate in the United States about the medical versus social role. In Great Britain, these services operate on the same general principle: to provide care to elderly persons with physical, mental, or social impairments on a day basis, with the patients maintaining their homes in the community and returning there in the evening. The major differences are in the auspices, staffing patterns, scope and variety of services, characteristics of patients served, and expected outcomes of treatment. Although a rather clear distinction has been made between the day hospital and the day center, in practice the differences between these units tend to blur and

the services tend to overlap. Table 1 summarizes the differences between the British day hospital and day center.

The day hospital is operated under the auspices of the Hospital Authority (responsible for medical services). In general, day hospitals are closely associated with geriatric or general hospitals and have access to the medical facilities of these hospitals. The overall emphasis of the day hospital is on medical diagnosis, treatment, and rehabilitation. Thus, the day hospital is equipped for diagnosis or assessment of those patients who do not need to be admitted on an in-patient basis but cannot be adequately assessed as out-patients, as well as for medical and nursing treatment for any condition that does not require skilled care around the clock. Social interaction opportunities generally are considered not as a primary purpose of day hospital care but as a beneficial side-effect. The patient population of the day hospital is defined by the available services and functions. Patients are expected to benefit from medical treatment by resident physicians and to be amenable to rehabilitation or at least maintenance of functioning through active treatment. Thus, the day hospital is neither a custodian nor a holding center for patients.

Day centers, on the other hand, are operated under the auspices of local authorities (responsible for social welfare services) or voluntary organizations. The ratios of paid staff and volunteers to patients vary. The emphasis of the day center is on the provision of social stimulation of participants and it serves as a holding center with supervisory and custodial functions. Most day centers provide company, meals, bath, chiropody, and occupational therapy. Participants receive necessary medical care from their own physicians.

Center participants are supposed to be less likely to benefit from short-term rehabilitation and treatment. Attendance at the day center may continue for many months. James Farndale

characterizes day center participants as "frail elderly" persons who are not able to maintain complete independence in the community or whose families need assistance in caring for them.

It can be seen from the definitions above that day hospitals and day centers are separate parts of a continuum of health care for geriatric patients. Several authors have suggested that an ideal relationship between the two forms of day care would be one in which a central day hospital could be served by several day centers. When day hospital patients improved to the point that they no longer needed medical treatment, they could be discharged to one of the day centers. There, they could receive the social stimulation and supervision necessary to maintain the level of functioning achieved in the day hospital. One reason for current retention of inappropriate patients in day hospitals is the lack of such coordinated services.

Although social day centers are available in only 55 per cent of the areas surveyed by Brocklehurst, it is interesting to note that they were three times more common in areas served by a day hospital. In the areas where both existed, they seem to have developed together. Since discharge from a day hospital is made easier by the presence of a day center, it may be that the day hospitals created, or made more obvious, a demand for social day care. The observation is supported by the authors' experience in the United States. 23

TABLE 1 CONCEPTUAL DISTINCTIONS BETWEEN THE BRITISH DAY HOSPITAL AND DAY CENTER

VARIABLES	DAY HOSPITAL	DAY CENTER
Auspices	Hospital authority closesly associated with geriatric or general hospital	Local authority or voluntary organization
Staffing	Salaried professional staff & aides	Salaried or volunteer staff or combination - no professionals required.
Service Emphasis	Medical	Social
Services	Diagnosis and evaluation; medical and nursing treatment; rehabilitation treatment (physical therapy, occupational therapy, speech therapy)	Social interaction, minimal supervision and custodial care, meals, bathing, occupational therapy at some centers
Patient Characteristics	More seriously disabled patients who do not need 24-hour skilled care and can benefit from active treatment	Less-seriously disabled patients in need of social stimulation and minimal supervision
Expected Patient Outcome	Rehabilitation to higher level of functioning	Maintenance at current level of functioning; prevention of deterioration
Location	Usually in long-term care hospitals	Old people's homes or free standing
Days of Operation	Five to seven days a week	Five to seven days a week
Cost to Patient	Usually none	Cost varies with locality

Day Care as a Long-Term Care Service

Rathbone-McCuan indicates that during the past four years, the geriatric day care center has become increasingly important to policy makers, service providers, and researchers concerned with the demonstration and evaluation of the concepts. There has been an attempt to move in the direction of a rational plan for introducing the concept in the United States. At the federal government level, three particular agencies within the former Department of Health, Education, and Welfare have assumed major leadership roles: the National Center for Health Services Research, Division of Long-Term Care; the Administration on Aging, Office of Human Development; and the Medical Services Administration, Division of Long Term Care, Social Rehabilitation Services. Even prior to the passage of P.L. 92-603 (Social Security Amendments of 1972), key individuals within these agencies were farsighted enough to work toward instituting a plan for select field experiments that would test the effectiveness and cost of geriatric day care center services. In addition, many other state and local governmental officials have worked actively to develop guidelines that could structure the expansion of day care services at the local level and eventually lead to the passage of legislation needed to support the delivery of these services nationally as part of the spectrum of health-social services for the aged.

Geriatric day care is a broad concept that applies to any service provided during the day. It encompasses many types of services ranging from home care to day hospital. It has been implemented for nutritional, recreational, social, and health programs, and is an increasingly popular means of providing services to older people.

Many taxonomies have been proposed for day care services. While these are helpful conceptually, they should not prevent flexibility for participants' needs and adaptability to local community needs. Philip G. Weiler and Eloise Rathbone-McCuan prefer to break down the major service modalities concerned with

day care centers as shown in Table 2.

Day care is a unique service modality because it can meet the long-term needs of those seeking service while also taking into account individual differences. It differs from outpatient services and senior centers in several important aspects: services are tailored specifically for each participant; each service has a theraputic objective --prevention, maintenance, or rehabilitation; each day is planned for each individual and activities are not chosen at random by the participant (as is the case in many senior centers).

Among the candidates for day care are people who are living alone and cannot completely care for themselves, people who are living with others who need relief from the total responsibility of their care, and people discharged from an institutional setting. They require services oriented to prevention of illness; maintenance, rehabilitation, and restoration of health; and social contacts to overcome the isolation associated with illness and disability.

Day care service is delivered on three levels: individual, center, and the broader care continuum. It is from these levels that the day care center delivery system will be analyzed in the following chapters. The levels provide independent but related perspectives that are useful in the planning, implementation, and evaluation of day care centers. No perspective is better or worse; they are applied according to professional orientation and special uses concerning day care.

The individual perspective stresses the participant's experiences and permits consideration of his or her position in relation to personal care, planning, service impact, and staff and family interactions. For example, most day care centers designate socialization as one major service goal. However, since socialization involves an individual social interaction through social roles influenced by other people, one must assume

TABLE 2 GERIATRIC DAY SERVICES

MODALITY	MAJOR SERVICE OBJECTIVE	TYPE OF CLIENT	SERVICE SETTING
Day Hospital	To provide daily medical care and supervision to help the individual regain an optimal level of health following an acute illness	Individual is in active phase of recovering from an acute illness, no longer requiring intense medical intervention on a periodic basis	Extended care facility or hospital
Social/ health center	To provide health care resources when required to chronically impaired individuals	Individual has chronic physical illness or disabilities; condition does not require daily medical intervention but does require nursing and other health supports	Long-term care institution or free standing center
Psychosocial center	To provide protective or transitional environment that assists the individual in dealing with multiple problems of daily coping	Individual has a history of psychiatric disorder; could reactivate and/ or suffer from mental deterioration (organic or functional) that places him in danger if he is not closely supervised	Psychiatric institution or free standing center
Social center	To provide appropriate socialization services	Individual's social functioning has regressed to the point where, without formal, organized social stimuli, overall capacity for independent functioning would not be possible	Specialized senior citizen center

an individual perspective to evaluate the experience.

The center perspective encompasses the day care center as a whole and allows for consideration of the quality and quantity of service. It emphasizes administrative and policy issues that are important to all day care center operations. For example, some day care centers have been established to provide an alternative to long-term institutional care, and cost-effectiveness is a major concern. To determine cost-effectiveness, one must consider the entire service operation.

The care continuum perspective approaches day care as part of a larger array of services and emphasizes planning, coordination, and community resources. For example, to determine if a center is required for a particular at-risk group, one must review the current array of a community's long-term care services to avoid duplication and to anticipate the possible links between the center and other services. Successful planning also requires an examination of what groups currently are and are not being served. 24

Since 1965 and the advent of Medicare and Medicaid, the number of nursing homes for the elderly in the United States has grown phenomenonally. Nursing homes have provided full time, long-term care for chronically ill and disabled older people whose illnesses have prevented them from being cared for at home. While only approximately five percent of the nation's million elderly are in institutions on any given day, one out of five aged people will spend at least some time in a nursing home during his/her later years. Older people are often placed in nursing homes for want of less comprehensive alternatives. Many specialists in the field of long-term care, including nursing home administrators, now see a pressing need to develop a fuller range of alternative models of care which would provide a level of service less inclusive than that of a long-term care institution. Such services would provide a way of accomodating those elderly who are not sufficiently disabled or intellectually impaired to really

need full time care in a traditional nursing home environment. Gustafson indicates that there may be resistance to day care for the aged by some people with an interest in long term care. The availability of day care will reduce the percentage of the aged population which will use long-term care beds. In the United Kingdom, where the goal is to keep the aged in the community and out of beds, the government maintains only 1.5 long-term care beds per thousand persons over 65. In the USA, we have 5 to 8 beds per thousand elderly persons (Hearings, 1971). This is what a strong day-care system combined with well-developed supportive services in the community can do. Only 1% of the population over 65 in the United Kingdom lives in long-term care facilities. In the USA, 5% are in long-term care institutions (Hearings, 1971). Because the population of the aging is growing, existing LTC beds will be filled and more. But there will be less need for them as day care becomes a wide-spread part of our health care system. On the other hand, day care will be a valuable service which will eventually be adequately financed, an important step in the right direction along the difficult path of caring for the many needs of the many aged people in our communities. (Gustafson, 1974). [25]

Abel [26] provides another perspective as to the role of day care centers as an alternative to institutionalization. She indicates that there is a desire in the nation to forestall the tragedy of alienation in an institution to help people retain their independence by providing them alternatives to institutionalization. A recent report from the subcommittee on health and long-term care of the House Select Committee on Aging urges that "nursing homes be encouraged to provide alternative day modes so that the elderly individual can see the entire continuum of care available to him in the same location, so as not to become unnecessarily accustomed to remaining in the institution and so that a possible transfer back home can be accomplished by continuing health care with which the patient feels comfortable." What is the place of the institution in this process? Charges

like Rep. Claude Pepper's (D., Fla.) of "institutional bias" in federal funding may strike terror in the hearts of the administrators of the nation's institutions, but in each of three programs recently examined by MODERN HEALTHCARE, the institution is at the heart of the de-institutionalizing process. (Abel, 1976).

However, Kane reflects a careful view of the role of the day care centers as an alternative to institutionalization. He suggests that before we can define our goals we must know more about where we want to go. We offer the following recommendations as next steps toward clarifying these goals. These recommendations are addressed broadly to both those who would undertake the tasks and those who would commission them. (1) A clear delineation of the alternative mechanisms to provide long-term care must be developed with a common vocabulary and a consensus as to measures of the outcomes, target populations, and costs that will be considered. (2) Preliminary decision analysis strategies should be utilized to evaluate the most feasible routes toward dealing with subsets of the population. Decision analysis will necessitate a clarification and specification of what types of outcomes we wish to maximize and how these different outcomes should be weighed relative to each other. The repertoire of outcomes should be broad enough to encompass socially desirable ends such as happiness and quality of life as well as the more usually considered elements such as functional status and costs. (3) Methodological issues in measuring health status of the elderly must be clarified; these include testing the validity and reliability of self-report and the predictive as well as face validity of the measures. (4) Specific research should be directed toward developing the concept of common units of service so that costs can be compared across differing programs (e.g., a refinement of the work described by Maddox and Dellinder (1978). This research should place particular emphasis on assessing the context in which such service units are delivered. (5) The emphasis on developing alternatives to nursing homes should not obscure the need for careful study of the cost-effectiveness of various strategies within given

alternatives (e.g., day care, home health, sheltered housing.) (6) The enthusiasm for alternatives should not detract from the need to improve institutional care. A finite proportion of the elderly will continue to need care in such institutions, either as a prelude to reentering the community of as a strategy of choice. The need for careful targeting of institutional programs to subgroups of clients is crucial. In this regard, attention should be given to determining the best institution-based technology for serving extremely disoriented individuals. (7) More attention should be given to the potential role of sheltered housing as an efficient and highly satisfying mode of delivering service. If priorities are given to the study of different kinds of alternatives, the sheltered housing concept seems to merit the highest consideration. (8) To aid in the development of appropriate alternatives, further research must be conducted around the abilities of different family groups to provide care for the elderly. Here we must distinguish between physical care in the home of the relative, physical care in the home of the aged person, and emotional support. (9) On the other side of the coin, the process of deinstitutionalization especially in early phases, merits careful descriptive study. If it becomes a matter of policy to remove individuals from institutions to alternative arrangements, records should be kept of the kind of alternatives implemented and their outcomes at various time intervals. Follow-up of representative samples of those discharges is important to provide a minimum data base about the effects of deinstitutionalization policies in terms of the outcome measurements--health status, happiness, etc.--that have been developed. Here we would wish not to replicate the problem of mental health organizations which implemented de-institutionalization programs but did not determine what happened to the individuals discharged. (10) New methods of financing and developing incentives for providers to use technology must be considered. Emphasis here should be placed on reimbursing providers on the basis of the outcomes achieved (Kane & Kane, 1976). Such a comparison would require the development of adequate predictors of function for either

individual clients or well-defined subgroups of clients. (11) Professional education of physicians, nurses, social workers and other service providers should be augmented to include sufficient information on aging and the needs of the aged to allow these professionals to function effectively as both providers of care and brokers at those critical times when decisions about institutional placement are made. (Kane, 1980).[27]

Robins [28] indicates that many communities searching for a way of describing, limiting or defining their adult day care programs have used the "models" concept. Providers have tended to use the "models" category or to have a "models" label assigned to their programs in order to indicate primary service emphasis, target populations and/or service combinations provided. As third party reimbursement became available, the "health" or "restorative" model became identified with Medicaid reimbursement, and the "social" model became identified with Title XX support. Increasingly, however, the differences are blurred. The 1980 Adult Day Care Directory classifies the programs as follows:

- Restorative programs are those offering intensive health-supportive services prescribed in individual care plans for each participant. Where prescribed, therapeutic services are provided on a one-to-one basis by certified specialists with constant health monitoring and provision of a therapeutic activities program.
- Maintenance programs are those with the capability (in terms of health professionals on the staff and appropriate equipment) to carry out a care plan for each participant based on recommendations from the personal physician (or clinic) and developed by the multidisciplinary program team. Services provided include health monitoring, supervised therapeutic individual and/or group activities, and psychosocial services.

- Social programs show wide variations in nature and scope. Some social programs place great stress on health maintenance, with nursing services an integral part of the total program; other social programs create formal linkages with local clinics or health departments and transport participants to needed services; still other programs are concerned solely with socialization and lunches.

Should there be distinct program models, or is it preferable to have a single program serving varying levels of need? Because of the changing levels of need of many participants, a growing number of authorities point to broad-based programs. This is an area worth investigating.

Zaki [29] in his study suggested the following recommendations:

1. Day care centers should not be considered as an alternative to institutional care. They are part of the wide spectrum of services offered to the elderly. There is a danger of comparing day care centers with institutions for the elderly. Both have their place in the field and both are necessary. The problem is that we failed to fill in the gap between institutions and the community.
2. If we accept the first premise, then, it is absurd to conduct cost analysis study for the purpose of comparing the cost of day care centers with the cost of inpatient institutions. Neither should be compared with the other, since each has its own distinct function in the wide spectrum of services for the elderly. However, with the advent of day care centers some of the inappropriately institutionalized elderly will be able to reside within the community and be served by day care centers which are less costly than in patient institutions.

3. Day Care Centers should utilize all resources in the community to serve their participants; i.e., mental health clinic, adult education agencies, recreational institutions, volunteers, state hospitals, etc.. An excellent example is demonstrated by the Deriatric Day Care Center of Elgin, Illinois. The Elgin State Hospital donates 30 hours per week of consultant services to the Center: 10 hours for social services, 5 hours from a psychologist, 5 hours from an Activity Therapist, and 10 hours from nursing.
4. Home bound services (out reach) are vital to the survival of day care centers. Services offered to the clients should not be limited to the activities conducted at the premises. The ideal situation is when the center extends its services 24-hours per day regardless where the participant is. As a principle, day care centers should avoid developing institutional patterns of rendering services. They have to cater their services according to the individuals' needs and interests.
5. The main function of day care centers should be the development of a therapeutic and supportive milieu for the participants. The staff should be trained in therapeutic interaction, counseling and group dynamics.
6. The role of the State AoA Offices relevant to day care centers should be as follows:
   a. Promotion of the concept by educating the public and social agencies as to the possibilities of establishing day care centers.
   b. Allocation of funds
   c. Training of staff
   d. Research and evaluation of programs
   e. Licencing and supervision
   f. Coordination of different services related to day care centers; i.e., transportation, meals, recreational programs, etc..

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Chapter III

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CHAPTER IV

The Transcentury Study

Due to the importance and recency of this study which was cited in Weiler and McCuan [30], the authors feel it is important to include it in their review. A national study, conducted by the Transcentury Corporation and sponsored by the National Center for Health Services Research under P.L. 92-603, considered adult day care as a possible benefit of Medicare coverage. It dealt exclusively with health-oriented programs, all of which were known either as adult day care centers or as day hospitals. A detailed discussion of this study provides a comprehensive overview of day care in the United States. The study got underway in mid-1974, using as a sample 10 programs in eight states representing as broad a mix as possible of urban and rural settings, organizational affiliations, program sizes, lengths of operation, and ethnicity of participants. The report described and compared the principal characteristics of these 10 prototypical programs, showing a wide variety of adult day programs in terms of patients served, differences in program objectives and services, alternative staffing patterns, and costs per patient-day.

Data Collection

Data came from site visits to all programs. A typical visit lasted roughly three days (except at programs with multiple sites, where visits lasted roughly four days), and required the services of a three-to-five-member team that spent roughly nine person-days (12 person-days at multisite programs) reducing and reporting the data for subsequent comparative analysis. Brief revisits were necessary in some cases. Data collection visits were organized around five protocols either developed expressly for this study or adapted for this study from an existing instrument. Table 3 lists the programs with some of the characteristics they contributed to the selected sample.

Comparison of the 10 Centers

Judging from the 10 centers, adult day care is often initiated in one of two ways: Either some gap in existing services to the impaired elderly is recognized and an adult day care center is developed specifically to fill it, or, less frequently, someone in the community in a position to influence

health care program decisions learns about concept of adult day care and promotes a center. Centers developed to fill a specific service gap had a clear sense of mission and an idea of where the service fit in the long-term care continuum.

Burke, St. Camillus, and St. Otto's are examples of adult day care programs initiated in response to a need for a service. The planning staff of the Burke Rehabilitation Center had discovered that some of its patients who were sufficiently recuperated to justify release from impatient status, but still in need of ambulatory rehabiliative care couldn't get such care locally. Burke Day Hospital now fills the gap, strongly favoring for admission those who need rehabilitative care. Its participants are primarily fracture and stroke victims. At St. Camillus, the outpatient department administrator had found that outpatients still needed, but could not get, some of the support services they had received as inpatients. St. Otto's was pulled into a gap in the Minnesota mental health care system as the volume of discharges from the state's mental institutions rose and the death of suitable ambulatory care facilities for the mentally ill became more profound.

San Diego and Montefiore are examples of the other type of program origin: where the idea preceded the program. In San Diego, a member of the county's board of supervisors was asked during a television interview what services were being sponsored for the aged in the county. The supervisor cited adult day care as an example. A community service agency for the elderly was then called upon to draft an idea paper on adult day care. What emerged was a broad program offering a wide range of services to a variety of elderly individuals. Emphasis is on social support services, but medical, health, and therapy services are available on referral or from a team of specialists. Most participants need rehabilitative or maintenance care. The Montefiore program was designed after officals were told of the possibility that funding for adult day care might be

available from DHEW. This left the designers free to produce a program aimed at meeting a wide variety of participant needs. Social dysfunction is sufficient for admission.

Another program, On Lok, defies categorization. Though it was designed in response to a study of deficiencies in the local long-term care delivery system. It is unique in that it was designed to fill not a specific gap but a general one. Services delivered by On Lok are the most comprehensive of the 10 programs, though many of them are social services, and though therapy services constitute a small percentage of staff time.

The Athens-Brightwood Day Care Center began operation in 1970. It originated when the homemaker/home health service agency thought it could provide therapeutic care at a lower cost in a supervised group setting. The center serves an average of 11 persons per day and is affiliated with a social service organization. It maintains a contractual meal service arrangement with a local senior citizen center and has an informal affiliation with a hospital-based home health care program.

The Tuscon Senior Health Improvement Programs began in 1968 as a single-site day care center whose primary objective was to prevent improper institutionalization. The program has undergone major expansion and diversification during this time and now offers services to an average of 115 persons per day. The program is part of a network of 16 day care centers in institutional and noninstitutional settings, and is coordinated by a central administration.

Physical Facilities

Quarters of the 10 adult day care programs range from luxury class to steerage. Burke and On Lok are two contrasting examples. At On Lok, participants crowd themselves and their wheelchairs into an L-shaped common activity room where arm pulleys hang from the ceiling and a T-bar exerciser stands

incongrously next to the folding tables and chairs that at lunch time turn the room into a dining hall. For three or four hours in the morning, the same tables are used by the program's participants for arts and crafts, reading, arguing or chatting with friends, and just sitting quietly. Occasionally, a participant will roll his wheelchair under the arm pulleys and practice an exercise taught him or her by the center's part-time physical therapist. Meanwhile, a speech therapist battles the high-decibel din while working with a stroke victim to regain the use of voice muscles. Two more participants sleep, or at least lie quietly, on rollaway beds behind a curtain partially drawn across one end of the L-shaped room. A small, partitioned examining room tucked into one corner and a bathroom with extra wide doorways to accommodate wheelchairs confirm the impression that the cavernous room is a health facility. Once it was a neighborhood cocktail lounge.

Burke Day Hospital is quite different. Though its stout brick and stone building is as old as some of its participants, it is obviously a fully equipped modern facility with its own X-ray machine, laboratory, and therapy rooms. Backup facilities duplicating the day care center's own, plus some the center does not have, are in the Rehabilitation Center if participants need them. Actual use of these backup facilities is infrequent, however.

St. Camillus contrasts with both On Lok and Burke by being totally integrated into the services and facilities of its parent organization, an extended care facility, without any special quarters for the adult day care program.

Two others, Tucson and San Diego, share a characteristic unique to them: They are both multisite operations. Each consists of a headquarters center plus several satellite centers. At each program, one administrative unit is in charge of all centers and some staff are shared by the satellites.

Criteria for Admission to Day Care Program

Most common criteria--participant cannot be:

- bedridden,
- totally disoriented,
- potentially harmful or disruptive,
- an alcoholic or drug addict,
- without medical need,
- a resident of a mental institution,*
- a resident outside the program's catchment area, unless he or she provides transportation,
- younger than 55 years old (preferred).

Exceptions made by some programs:

- participants of all ages accepted,
- a personal physician is not required,
- persons who live in mental institutions, nursing homes, or personal care homes accepted,
- participant must be oriented to person, but not necessarily to place and time,
- participants can be disruptive, as long as they are not harmful to themselves or others.

Additional restrictions made by some programs--participants must:

- be over 60 years old,
- have a family member or family surrogate to provide supervision and care during nonprogram hours,
- be eligible for one of three levels of institutional care,
- be eligible for Medicaid or be able to pay own bills,
- not be frequently/habitually incontinent,
- not require constant supervision due to disorientation,
- be able to use a walker in an emergency, if he or she is wheel-chair bound,
- not be subject to cardiac arrest,
- not require a special diet.

*St. Otto's is an exception and the effect has been profound. It began as a geriatric program but evolved into a psychiatric program after the state began massive releases of residents of mental institutions.

Intake and Review Procedures

As with admission criteria, the programs' intake and review procedures vary widely. Every program has established these procedures, but the process and the professional backgrounds of personnel used to conduct them are quite dissimilar.

All of the programs request that the applicant's personal physician (if there is one) perform an initial medical evaluation, and all but one of the programs use a multidisciplinary team to prepare the participant's plan of care. The team consists at least of a nurse practitioner, a physical therapist, an occupational therapist, a speech therapist, a social worker, and a director of patient activities. However, only On Lok has a staff physician as a regular member of the final evaluation team.

Procedures common to most programs:

- Initial screening is done by registered nurse and/or social worker.
- Staff social worker obtains a social history.
- Participant's personal physician is asked for medical record and to perform an initial evaluation.
- Participant's personal physician must provide medical clearance for program activities.
- Functional assessments are conducted by the registered nurse physical therapist, and occupational therapist.
- Final evaluation on program admission is done by interdisciplinary team, not including a physician.
- Plan of care is prepared by multidisciplinary team including at least a registered nurse and a social worker.
- There is an informal one-month trial period.
- Participant's progress is reviewed at least every six weeks.

Procedures employed by only a few programs:

- All referrals are screened initially by a central intake unit composed of social workers.

- Initial screening is conducted by social worker only.
- Initial screening is conducted by social worker and registered nurse in the applicant's home.
- If there is a need for verification of an applicant's medical status, a physician from the affiliated health facility is called in during the initial screening process.
- Applicants referred by one of the program's funding sources have already been screened by a social worker and determined eligible for day care services.
- The intake-orientation phase lasts for three to eight weeks, during which the applicant attends as a regular participant.
- Medical examination/evaluation is performed by the staff physician.
- Only the applicant's personal physician performs a functional assessment.
- Multidisciplinary intake and assessment team consists of a registered nurse, registered physical and speech therapists, a registered recreational therapist, a dietitian consultant, and a social worker.
- New participants receive a screening/assessment from a dentist, a podiatrist, and an ophthalmologist.
- Final decision on program admission is made by the applicant's personal physician and the backup medical panel of the affiliated health facility.

Participant Characteristics

Participants in these 10 adult day care programs are varied in their demographic and health characteristics. Several centers serve a particular racial or ethnic group. On Lok is a typical example; it serves a catchment area that is predominantly of one ethnicity, in this case Chinese.

Average age varies by program, too. While the average age for the 10 programs studied is 71, Burke has many participants younger than 60 and one participant, a paraplegic, who is only 22. At Burke, more than half the population is partially or totally

paralyzed. At St. Camillus, just under half are similarly afflicted. At most other programs, paralyzed participants make up between a tenth and a third of the population. Wheelchair use is similarly heavily skewed. Three-quarters of the participants at St. Camillus and half those at Burke use a wheelchair all the time or some of the time.

Burke and St. Camillus also have the greatest number of participants suffering from fractures and strokes. Mental illness, the primary diagnosis of nearly three-fourths of the participants at St. Otto's , afflicts between a quarter and a third of participants in 5 of the 10 programs. Hypertension is a ubiquitous affliction among adult day care participants. Blindness is rare, yet at every program except St. Otto's and San Diego there is at least one blind participant.

Overall, the participants included in the sample tended to have between two and five diagnosed medical problems (see table 4).

Staffing and Health Care Services

Several programs depend on affiliated institutions to provide therapies. Others depend on in-house staff. Tucson has a large staff of professional, allied, and associated health care personnel, but since it also has the largest population, it has, paradoxically, one of the proportionately smaller staffs. Burke has the highest ratio of staff to participants. St. Otto's eleven participants are served by the equivalent of fewer than three full-time staff members. The result overall is a range of nearly one staff member for every five participants at St. Otto's.

Services

Few aspects of adult day care better evidence its evolving nature than the heterogeneity of service packages. Every program offers a core of basic services without which it

could not function. But the similarities end there. What is most indicative of the fledgling nature of the program is that there is no apparent agreement on what marginal services have priority. The following basic and marginal services are offered in numerous combinations.

Basic services offered by all programs:

- general nursing services,
- referral to community services including: emergency services at hospital, emergency services of physician, ambulance transportation, hospital inpatient care, rehabilitation center, mental health facility, senior citizens' center, nursing home, community health center, visiting nurse/homemaker service, health specialists/consultants,
- social work services,
- recreation activities,
- assistance with activities of daily living,
- supervision of personal hygiene,
- lunch.

Additional services offered by some programs

- two meals of day,
- snacks,
- nutritional counseling,
- meal-on-wheels,
- physician services
- speech, physical, and occupational therapy,
- psychiatric services,
- psychological services,
- limited diagnostic services,
- rehabilitative nursing,
- music therapy,
- reality therapy,
- health education,
- sheltered workshop,
- laundry,
- transportation,
- home care services.

Additional services offered by some programs (through an outside source):

- diabetic treatment and care,
- ophthalmology,
- podiatry services,
- dental services,
- specialized diagnostic services,
- vocational rehabilitation,
- radiology.

Costs

The wide variations among adult day care programs in their physical facilities, staff size, variety of health professionals, and available services may take some difference in their ability to serve different populations. But there can be no doubt that they make a difference in their costs.

Daily costs at Burke are much higher, for nearly every function, than any other program (see table 3.3). In fact, costs are nearly twice as high there as at the next most costly programs ($21.04 per day). But with that exception, costs fall within a fairly narrow range.

Table 3 Adult Day Care Centers Selected for Transcentury Study

Center	Average Daily Attendance*	Principal Funding Source	Months in Operation	Affiliation	Days per Week in Operation	Location
Tucson Senior Health Improvement Programs	115	Model Cities	92	Nursing home/ hospital	5	Tucson, Ariz.
San Diego Senior Adult Day Care Program	52	Revenue Sharing	20	Social service organizaiton	5	San Diego, Calif.
On Lok Senior Health Services Center	47	Title IV, OAA	27	Free standing	7	San Francisco, Calif.
Burke Day Hospital	40	Title IV, OAA	27	Rehabilitation Center	5	White Plains, N.Y.
Lexington Center for Creative Living	29	Title IV, SSA	25	County Health Department	5	Lexington, Ky.
Mosholu-Montefiore Geriatric Day Care Program	28	Title IV, OAA	26	YMHA-YWHA/ hospital	5	Bronx, N.Y.
Levindale Adult Day Treatment Program	25	Medicaid	60	Geriatric center	5	Baltimore, Md.
St. Camillus Health Care by the Day Program	18	Medicaid	34	Skilled nursing facility	5	Syracuse, N.Y.
Athens-Brightwood Day Care Center	11	Title VI, SSA	36	Social service organization	5	Athens, Ga.
St. Otto's Day Care Program	11	Medicaid	79	Nursing home	5	Little Falls, Minn.

* Figures reflect study team findings of actual attendance on site visit days and program records of lunches consumed in sample months. Tucson program officials disagree with figures for their program. Their estimate is 143.

Occurrence of Chronic Conditions and Impairments of Participants at Each of 10 Adult Day Care Programs
(sample size for each program = 30)

Medical Problem	Athens #	Athens %	Burke #	Burke %	Levindale #	Levindale %	Lexington #	Lexington %	Montefiore #	Montefiore %	On Lok #	On Lok %	St. Camillus #	St. Camillus %	St. Otto's #	St. Otto's %	San Diego #	San Diego %	Tucson #	Tucson %
Angina	2	(7)	3	(10)	5	(17)	0	(-)	7	(23)	2	(7)	1	(3)	2	(7)	2	(7)	0	(-)
Myocardial Infarction	2	(7)	6	(20)	1	(3)	0	(-)	3	(10)	0	(-)	1	(3)	2	(7)	0	(-)	4	(13)
Cardiac Arrythmias	0	(-)	9	(30)	10	(33)	0	(13)	4	(13)	5	(17)	4	(13)	1	(3)	3	(10)	3	(10)
Congestive Heart Failure	3	(10)	8	(27)	8	(27)	12	(40)	7	(23)	9	(30)	2	(7)	1	(3)	0	(-)	1	(3)
Hypertension	13	(43)	21	(70)	13	(43)	15	(50)	13	(43)	12	(40)	12	(40)	6	(20)	13	(45)	13	(43)
Cerebrovascular Accident	6	(20)	14	(47)	3	(10)	6	(20)	4	(13)	12	(40)	10	(33)	1	(3)	6	(20)	10	(33)
Arteriosclerosis	10	(33)	19	(63)	3	(10)	14	(47)	19	(63)	18	(60)	6	(20)	3	(10)	7	(23)	9	(30)
Arthritis	15	(50)	9	(30)	7	(23)	10	(33)	17	(57)	10	(33)	8	(27)	3	(10)	7	(23)	9	(30)
Diabetes	7	(23)	7	(23)	9	(30)	9	(30)	8	(27)	8	(27)	2	(7)	0	(-)	3	(10)	7	(23)
Mental Illness	7	(23)	8	(27)	10	(33)	1	(3)	11	(37)	6	(37)	4	(13)	21	(70)	2	(7)	9	(30)
Neurologic																				
Chronic Brain Syndrome	3	(10)	0	(-)	1	(3)	6	(20)	4	(13)	5	(17)	0	(-)	4	(13)	5	(17)	3	(10)
Mental Retardation	0	(-)	0	(-)	3	(10)	0	(-)	0	(-)	0	(-)	0	(-)	6	(20)	1	(3)	0	(-)
Parkinsonism	2	(7)	0	(-)	6	(20)	0	(-)	1	(3)	2	(7)	1	(3)	1	(3)	2	(7)	0	(-)
Other	1	(3)	6	(20)	4	(13)	3	(10)	2	(7)	1	(3)	8	(26)	2	(7)	1	(3)	0	(-)
Respiratory																				
Emphysema	2	(7)	0	(-)	1	(3)	3	(10)	0	(-)	6	(20)	6	(20)	1	(3)	1	(3)	0	(-)
Other	1	(3)	1	(3)	0	(-)	4	(13)	1	(3)	1	(3)	2	(7)	1	(3)	0	(-)	2	(7)
Paralysis/Paresis	3	(10)	16	(53)	3	(10)	6	(20)	3	(10)	9	(30)	13	(43)	1	(3)	6	(20)	10	(33)
Fractures	4	(13)	6	(20)	1	(3)	1	(3)	4	(13)	3	(10)	8	(27)	1	(3)	4	(13)	4	(13)
Blindness	1	(3)	3	(10)	1	(3)	1	(3)	1	(3)	1	(3)	1	(3)	0	(-)	0	(-)	1	(3)
Average number of medical conditions per participant	2.7		4.8		2.9		3.3		3.9		3.5		3.0		2.0		2.1		3.0	

Conclusions

The preceding data suggest several things about the nature of adult care in the United States. First, adult care may be a special mode of care in one important respect: Its characteristics change from one center to the next. Virtually no statement can be made about patient characteristics, services, staffing, or costs without at least one exception. Second, what the 10 centers studied have in common is that in most cases they are highly adaptive to the local health care delivery system and local aged population's needs. What is missing from that system can be found in the adult day care program; what is already available usually is not duplicated.

Table 5 Per Diem Costs in 10 Day Care Programs

Center	Cost
Burke	$ 61.56
Montefiore	33.67
St. Camillus	24.51
On Lok	23.45
Athens	21.70
San Diego	20.94
Tucson	20.32
Levindale	16.97
Lexington	16.56
St. Otto's	11.26
Average for all 10	$ 25.09
Average excluding Burke	$ 21.04

This finding more than any other may point to great promise for adult day care in the United States, because it

hints that growing resistance to further proliferation of new health care facilities (e.g., certificate of need laws) will not be a barrier to the development of programs. Tailored as they are to gaps in the existing system and shunning duplication, they meet the optimal standards of health planners.

Yet this very strength could retard growth, at least temporarily, if the growing concern about health care quality standards forces local program planners to adopt a standardized program definition instead of focusing on designs specially tailored to local conditions and patient needs. Without such tailored programs, adult day care might price itself out of the market even if quality of life is improved. At more than $21 for a four-hour day, the day care program is more expensive than a nursing home program (which averages $16 per day according to DHEW's 1975 Nursing Home Survey) for anyone who comes more than a couple of days each week.

A third influence in the health care policy field may solve the problem, however. This is the tendency of some officials to opt for decentralization of control over health care resource expenditures, favoring state and local level decision making over national policies. Former President Ford's health proposals in his 1976 budget message were good examples. He proposed collapsing some 59 categorical health programs into one block grant to the states. This found little support in Congress, but the fact that it was proposed may indicate that some support exists for putting the local power to design health programs into the hands of those close enough to local delivery systems to see gaps and work to fill them. No program could be better suited to such flexibility than adult day care. If decentralization catches on, adult day care has a good chance of catching on with it.

The national expansion of adult day care, however, is further complicated by the following:

1. Even though many facilities use the name, there is no nationally accepted definition or concept of geriatric day care centers.

2. There is no clear philosophy to guide health and social service components on long-term care.

3. There is no national funding mechanism for day care.

4. Despite much governmental and professional involvement in day care, many, if not the majority, of centers develop in isolation; only a few states have established guidelines for the creation of day care centers.

Until the national problems are resolved, however, new initiatives in the development of adult day care must continue to be taken on the state and local level.

CHAPTER V

ANALYSIS AND INTERPRETATION

INTRODUCTION

In the catchment area of the Southeastern New England Long Term Care Gerontology Center there are twelve day care centers; six in Massachusetts, and six in Rhode Island. One center in Rhode Island, Adult Day Care Program, East Providence, is not fully functioning and it accomodates only one or two clients. The nature of the program is social. The authors decided to exclude it from the survey. (See Appendix 3: List of Day Care Centers within the catchment area).

An important dimension bearing on our study is that day care centers within the catchment area in the State of Massachusetts are established according to the regulations of the Department of Public Welfare and are accepted as Medical Assistance agencies (Medicaid), while in the State of Rhode Island no such regulations exist. (Appendix 4: Adult Day Health Manual, The Commonwealth of Massachusetts). The State regulations provide us with a baseline from which we can evaluate the structure and functions of these centers, while in Rhode Island there is no such measure.

1. COMPARISON OF THE CENTERS

Some of the centers (4) were established through community initiative either by individuals or community agencies, e.g. church groups and Community Action Programs. The rest of the centers (7) were established through community agencies which are already involved in the field, e.g. nursing homes, hospitals and Visiting Nurse Associations. Examples of the first category are Cranston Senior Citizen Day Care Center established as a community action program agency (CAP). Fruit Hill Day Center for Elderly was initiated by residents of a convent. Central Geriatric Day Care Center started through the efforts of a church group. Westerly Adult Day Care Center was initiated by a group of citizens who felt the need for such a center.

The second category includes centers which were established by agencies offering direct services to the elderly population. The Taunton Adult Day Health Center was established by the Taunton Visiting Nurse Association. The idea of Barnstable County Hospital Day Health Center was conceived and nurtured by a medical doctor and social worker at the hospital. The rest of the centers in this category were established as an extension of existing nursing homes; Comprehensive Day Care, Dartmouth Douse Adult Day Care, Windsor Adult Day Center, Fall River Adult Care Center, and Lutheran Geriatric Day Care Center. According to the Transcentury Study, centers developed to fill a specific service gap had a clear sense of mission and an idea of where the service fit in the long-term continuum.

The State of Rhode Island takes the lead in establishing day care centers; three of its centers have been in operation for over ninty two months (8 years in average). All the centers in Massachusetts, within the catchment area, have been in operation for 36 months in average except Barnstable County Hospital Adult Day Center which has been in operation for sixty months. It

seems that the approval of Medicaid coverage for day care centers' clients in the State of Massachusetts is the reason for the expansion of day care services in this state.

2. PHYSICAL FACILITIES

Quarters of the eleven centers range from free standing buildings (Central Geriatric, Warwick) especially designed and built as a day care center to buildings connected or part of a hospital (1), church (2), convent (1), multipurpose center (1), and nursing homes (5). The impact of the proximity to these agencies may have various consequences. Some of the centers do not have a separate budget, and some of the centers rely heavily on these agencies for services offered to their clients. Some of the clients expressed their resentment to the locality of the centers in nursing homes. They felt that it was very depressing to be at a center attached to a nursing home with all the stigma attached to it.

All the centers are accessible to handicapped persons. The facilities available to the clients vary from complete and separate for dining, kitchen, resting, nursing (bed baths), counseling, physical therapy, recreation, and crafts (4), to centers which do not have space for all these activities (7). Usually if the center is attached to a nursing home, the kitchen and some other facilities are shared.

3. CRITERIA AND PROCESSES FOR ADMISSION TO DAY CARE CENTERS:

Each of the centers in the catchment area developed their own criteria for selection and admission of clients. The majority of the clients of the Massachusetts' centers are Medicaid recipients. To be eligible for such coverage the following criteria are implemented:

A. Medical Assistance Recipients

The Department pays for adult day health services provided to adult Medical Assistance recipients (categories of

assistance 00, 01, 02, 03, 05, 06, 07, and 08) who meet the elgibility requirements below.

(1) A Medical Assistance recipient is eligible for enrollment as a participant in an adult day health program if:

(a) his medical condition indicates a need for nursing care, supervision, or therapeutic services that alone or in combination would normally require him to be institutionalized;

(b) his psychosocial condition is such that, without program intervention, his medical condition would continue to deteriorate, or he would be institutionalized; or

(c) his primary diagnosis is psychiatric in nature, but his condition is stable enough to allow him to participate in and benefit from the program. When a referred individual's needs for psychological services are beyond the capabilities of the program's staff members, the program must be assured, prior to the individual's admission, that he is receiving the necessary services from an appropriate resource.

(2) A Medical Assistance recipient is not eligible for enrollment as a participant in an adult day health program if:

(a) his need for 24-hour care cannot be met in a six-hour structured day program combined with a community or family evening and weekend support system;

(b) his primary needs are social and may be met through a senior-center program or less-structured social-activity program;

(c) his behavior may be harmful to other program participants or staff members;

(d) his behavior may be very disruptive; or

(e) his primary diagnosis is psychiatric in nature and his condition is not stable enough to allow him to participate in and benefit from the program.

(3) The Department will not pay for adult day health services provided to a participant who is a Medical Assistance recipient, unless the recipient's participation has been approved by the Department in writing in accordance with Subsection 405(E).

(4) Adults referred to the program must be willing to attend the program a minimum of two full six-hour days per week, unless a special written agreement has been approved by the Department waiving this requirement.

B. General Relief Recipients

The Department does not pay for adult day health services provided to General Relief recipients (categoy of assistance 04).

All of the centers accept clients regardless if they live alone or with family, friends, or in community agencies. However, some centers face difficulties in recruiting elderly who are living by themselves. All centers accept clients residing within their locality, usually decided upon by the distance from the clients' residence to the center. Most of the centers indicated that they recruit their clients from nursing homes, doctors, hospitals, home care agencies, families, social service agencies, and many community agencies.

Regarding age as a criterion, one center only accepts 65+ clients. Four centers only accept 55+ clients, two centers accept 18+ clients, and four centers accept clients who are 16 years old or over. This age mix at centers accepting any client over 16 years may have some implications; i.e., serving the psychosocial as well as biological needs. It is probable that the Medicaid eligibility criteria of covering all adults over 16 years may lead centers not to restrict their clients to the elderly age group. The survey of literature did not provide the authors with any studies conducted to explore the impact of the diversity of age.

Centers in the catchment area accept clients with various degrees of impairments. The following tables indicate the number of centers which accept clients with certain degree of impairments, and the different criteria developed by these centers for accepting clients.

Table 4: Summary of Degree of Impairment Criteria

	Incontinence	Homicidal	Suicidal	Alcoholism	Handicapped	Rely on Walker	Retarded	Depressed	Disoriented	Schizophrenic	Paranoid	Any other mental disorder	Other
BARNSTABLE	VS	CNA	COND	S	VS	VS	S	VS	VS	M	M	—	*
DARTMOUTH	VS	S	CNA COND	CNA COND	VS	VS	VS	VS	VS	—	COND	—	*
FALL RIVER	M	M	M	M	M	M	M	M	M	M	M	M	*
LUTHERAN	M	M	VM	CNA	VS	VS	M	VS	M	M	M	—	—
TAUNTON	M	CNA	CNA	M	S	VS	S	S	S	S	S	—	—
WINDSOR	M**	CNA	CNA	COND	VS	VS	M	S	S	M	M	—	*
CENTRAL	VS	M	M	S	S	VS	VS	VS	VS	S	S	—	—
COMPREHEN.	M	M	M	VS	VS	VS	VS	VS	VS	M	M	—	*
CRANSTON	M	CNA	CNA	M	VS	VS	S	S	S	S	M	—	*
FRUIT HILL	S	CNA	M	M	VS	VS	VS	VS	VS	M	M	—	—
WESTERLY	M	M	M	VS	VS	VS	M	VS	VS	S	VS	CNA	—

VM--Very mild
M--Mild
S--Severe
VS--Very Severe

COND--Conditional
CNA--Client Not Accepted
* Will not accept abusive or disruptive clients
** Urine only

Table 5: Variations Among Centers re: Physical and Psychosocial Impairments Criteria

	Very Severe	Severe	Mild	Very Mild	CNA
a. Incontinence	3	1	7		
b. Homicidal			5		6
c. Suicidal			6		5
d. Alcoholism	2	2	5		2
e. Handicapped**	8	2	1		
f. Rely on Walker	10		1		
g. Retarded	4	3	4		
h. Depressed	7	2	2		
i. Disoriented	6	3	2		
j. Schizophrenic		4	5	1	1
k. Paranoid	1	2	8		
l. Any other Mental Disorder			2		

* Client not accepted

** Could not move without Wheelchair

Intake and Review Procedures

As with admission criteria, the programs' intake and review procedures vary widely. Similar to the results of the Transcentury Study, every program has established these procedures, but the process and the professional background of personnel needed to conduct them are quite dissimilar.

All of the programs request that the applicant's personal physician perform an initial medical evaluation. The clients applying for medicaid coverage are requested to provide the center with specific medical information from a physician. (See Appendix 4, 405, (A), p. 4-4). All centers conduct physical assessment by different professionals; e.g., nurse or social worker. The psychosocial needs assessment is done by social workers at the client's residence at only two centers. The rest of the centers conduct the assessment by a social worker at the center (3), or by the director who is an R.N. or administrator (6). Only eight centers visit the homes of clients prior to admission to assess living conditions. All families of clients are interviewed prior to admission by all centers. The following table indicates the processes of admission.

Table 6: Procedures of Admission Prior to Acceptance

	Prior to Acceptance				
	Medical Form Required	Phys. Assess-ment	Psycho-Social Assessment	Living Conditions Assessment	Family Interviews
Barnstable	MD	DIR RN	DIR RN	DIR RN	DIR RN
Dartmouth	MD* RN	Yes	SW	RN SW	SW
Fall River	MD*	MD	SW RN	RN DIR SW	SW DIR RN
Lutheran	MD*	DIR RN	SW	DIR RN	DIR
Taunton	MD*	MD RN	RN	RN	RN
Windsor	MD*	DIR	DIR	NO	YES
Central	MD*	SW	SW	SW	SW
Compreh.	MD*	MD RN	SW	RN DIR	SW
Cranston	MD*	DIR	DIR	NO	DIR
Fruit Hill	MD*	RN MD*	SW	SW	SW
Westerly	MD* DIR	MD* RN	DIR	DIR	DIR

Table 7: Procedures Upon Acceptance

Upon Acceptance

	Formal Client Orientation	Family Orientation	Medical Plan Provided	Diet Provided	Counselling For Client & Family
Barnstable	NO	NO	YES	YES	YES
Dartmouth	NO	YES	YES	YES	YES
Fall River	NO	NO	YES	YES	YES
Lutheran	YES	YES	YES*	YES*	YES*
Taunton	YES	YES	YES*	YES	YES*
Windsor	YES	YES	YES*	YES*	YES
Central	YES	YES	YES	YES	**
Compreh.	YES	YES	NO	YES*	**
Cranston	YES	YES	YES	YES	YES
Fruit Hill	YES	YES	YES	YES	YES
Westerly	YES*	YES*	YES	YES	YES*

* Outside of center ** Makes outside referrals

The data does not totally support the notion that the centers located in the State of Massachusetts comply with the Admission Procedures specified in Appendix (4), pp. 4-5. The regulations require, aside from the physician's documentation, a pre-admission interdisciplinary team assessment. Some of the centers have neither the qualified staff nor the structured process to comply with the State regulations.

Upon admission, all centers conduct orientation sessions for the clients which vary in duration from two hours to one day (free of charge). In one center the final contract of admission is signed only after the client has been at the center for one month. Only two centers require families to attend orientation. The rest of the centers accept families to visit if they request it. At one center it is required to have family conferences four times per year.

Most of the centers attempt to develop individualized care plans for their clients, especially in the areas of medication and diet. There are no structured psycho-social treatment plans for patients in most of the centers (9), and, counselling is conducted by a variety of personnel; e.g., social worker, psychologist, nurse either on the premises (only one center) or at mental health facility. The staff meetings are an important aspect in revising care plans. Only six centers have structured weekly staff meetings. Two centers indicated that they share the information about changes among clients periodically, while three centers do not have any structured meetings for their staff to discuss care plans. Only two centers implement the team approach.

Again the data does not support the notion that all the centers in the Massachusetts catchment area are complying with the guidelines of Program Regulations (Appendix 4, pp. 6-7).

Participants' General Profile

Participants in these eleven day care centers are varied in their demographic and health characteristics. While interviewers were conducting their interviews, they were asked to interview a sample of clients, if both the director and clients would agree. Seven centers accepted to conduct the interviews. The samples are not representative of the total population, but they provide us with a picture of their general characteristics. The number of clients who consented to be interviewed was twenty-nine (29). This constitutes 10% of the average daily attendance of all centers combined, or from 7% - 20% of the capacity of clients of the consenting centers. This, in average, is an adequate sample for our purposes.

General Characteristics

The sample is seven (24%) males and twenty two (76%) females. The following tables describe the general characteristics of the sample.

a. Marital Status

Table 8: Marital Status of Respondents

	Number	Percent
Never Married	4	14
Married	2	7
Separated or Divorced	5	17
Widowed	18	62
Total	29	100

b. Educational Background

Table 9: Educational Background of Respondents

	Number	Percent
Grade School	14	48
Attended High School	13	45
Some College Education	2	7
Total	29	100

c. Occupational Background

Table 10: Occupational Distribution of Respondents

	Number	Percent
Blue Collar	12	42
White Collar	11	38
Housewives	6	20
Total	29	100

d. Age

The age of the respondents ranges from less than 65 to 80+. The following table reflects the age distribution of respondents.

Table 11: Age Distribution of Sample

AGE	Number	Percent
-65	5*	17
65-70	4	14
71-75	11	38
76-80	4	14
81+	5	17
Total	29	100

* One of the clients is twenty five (25) years of age. The median age is seventy-two(72) and the mean age is seventy-two (72).

e. Length of Time at Center

The respondents have joined the day care centers for periods of time ranging from (3) to (84) months with an average of (20) months. The median is a twelve (12) month period.

f. Living Arrangement

The living arrangements for the respondents is as follows:

Table 12: Living Arrangements for Respondents

		Sample	Total Population
Living with Spouse	2	7%	12%
Living with Family	13	45%	42%
Living Alone	11	38%	41%
Living in an Institution or Group Home	3	10%	5%
Total	29	100	100

Table 13: Living Arrangements for Clients According to Centers

Residences

	Barnstable	Dartmouth	Fall River	Lutheran	Taunton	Windsor	Central	Comprehen.	Cranston	Fruit Hill	Westerly
	%	%	%	%	%	%	%	%	%	%	%
Spouse	39	12	0	10	19	17	0	4	4	28	4
Children	9	76	0	44	22	47	52	20	58	46	40
Relatives	4	0	42	10	16	6	0	2	0	0	0
Friends	29	0	0	0	0	6	0	0	0	0	0
Alone	9	12	58	36	37	18	28	63	38	26	40
Institution	4	0	0	0	0	0	0	4	0	0	4
Other	4	0	0	0	6	6	20	4	0	0	12

1. Physical Conditions of Respondents

When asked if they were admitted to a hospital within the last five (5) years, the majority (19/66%) said yes and (10/34%) said no. The causes of hospitalization cited are: stroke (5/17%), leg problems (4/14%), hypertension (3/10%), manic depression (2/7%) and the rest; various reasons (5).

The majority of respondents (20/67%) stated that they are on medications, however, only (5) need help in administering these medications.

Only seven (24%) respondents are on special diets while the majority (22/76%) are not.

The majority (17/59%) of the respondents use neither wheelchair nor cane/walker, seven (7/24%) rely on cane or walker and five (5/17%) rely on wheelchairs.

When asked if they had contacted a cold or flu within the last year, the majority (15/52%) had cold or flu two or three times, two (2/7%) contacted either five or more times, three (3/10%) only once, and nine (9/31%) never contacted either.

The majority (18/62%) of clients never smoked, eight (8/27%) used to smoke but stopped, and only three (3/1%) are smokers and have been for over five years.

The majority of respondents (25/86%) indicated that they do not use any hearing device, and only four (4/14%) use such a device. Eighteen (18/62%) of the respondents wear glasses or contact lenses, while ten (10/35%) never use them. All respondents indicated that they had their vision checked within the last two years.

The majority of respondents (20/69%) indicated that they have occasional complaints about their physical condition, seven (7/24%) had several physical complaints, while two (2/12%) always have physical complaints.

On a continuum, one (active) to ten (frail) centers were asked to place the majority of their clients. The majority of the centers (5) selected 8 as the point on the continuum where they would place the majority of their clients. Four centers identified (5) as the point on that continuum, while one center selected (4).

Table 14: The Directors of Centers Estimation of Clients Physical Conditions

(Active)1	2	3	4	5	6	7	8	9	10(Frail)
Number of Centers			1	5			5		

g. Level of Functioning

The following table describes the level of functioning of the respondents.

Table 15: Some Aspects of Level of Functioning of Respondents

	Never	Sometimes	All Times
Difficulty dialing telephone	18	11	
Difficulty reaching objects in high places	3	15	11
Difficulty picking up objects from floor	10	12	7
Difficulty cutting food	21	4	4
Difficulty walking up and down steps	14	4	11
Difficulty rising from chair or bed	12	6	11
Suffer from dizzy spells	11	17	1
Normal activities cause fatigue	7	21	2

h. Average Attendance

The following table indicates the average attendance of respondents per week.

Table 16: Average Attendance of Respondents per Week

Number of Times per Week	Number of Respondents	Percent
5	14	48
4	4	14
3	5	18
2	5	17
1	1	3
Total	29	100

Almost half of the respondents attend all time; i.e., five times per week. The average weekly frequency of attendance of a client is 3/4 days per week.

Budgets and Financial Resources

a. Sources of Funding

The sources of funding of these centers vary from one center to another. However, the majority draw funds from Act Title III, SRS, SSI Medicaid (in Mass. only), fund raising and fees. Those which are attached to an agency; e.g., hospital, nursing home or senior citizens center are part of the total budget of the agency.

b. Budget

The yearly budget of the centers vary according to size and number of clients served. The highest budget is $250,000.00 (Warwick, 46 clients), while the lowest was Windsor Adult Day Center ($39,000.00, 12 clients). Some of the centers (2) refused to furnish any information about their budgets.* According to the data collected from some of the centers the main budget item is personnel (60-80%) while the rest is allocated for capital and operation.

The average per capita spending per year (Budget ÷ Number of registered clients) ranges from $1600 to $3800. The mean is $2585 and the median is $2400.

c. Capacity and Attendance

The capacity of centers vary considerably, 18-55 clients. Four centers can accomodate 55-40 per day. One can accomodate 30, and the rest (majority) (6) centers can only accomodate 10-28 clients per day. The number of clients which can can be accomodated at any day in the total catchment area is 300-370 clients. The average daily census of clients attending the centers is 260 per day. The highest number of clients is in the Warwick center. The number of clients registered in these centers is 320 clients. Only five of the centers have waiting lists for clients.

* All efforts failed to convince the administrators of these centers to provide us with budget figures. No reasons were given for their refusal, though it was clear to them that these figures would be used for the purpose of research. We believe that these figures are a public record and should be available upon official request.

d. Rates

The rates charged by the centers vary from one center to another, from $0-$22 a day. All the centers in Mass. are subsidized by Medicaid if clients are eligible. One center charges $4.00 for transportation for one way trip per day if needed by client. Many centers use sliding scale by family or client income.

The mean of rates centers charge clients per day is $16.2 and the median is $18.8. Four of the Centers use sliding scales in figuring the rate for different clients.

Table 17: Summary of Data About Centers

	Months in Operation	Present Funding Sources	Yearly Total Budget	Per Capita Spending per Year	Rate per Day	Client Capacity	Client Registration	Average Daily Attendance	Attendance of Client per Week	Hrs. per Day/ Days per Week	Minimum Age for Admission
Barnstable	60	Medicaid VA Conn. Gen. Private	$70,000	$3181	$20	15	22	13	4	8/5	16+
Dartmouth	36	Medicaid Fees	$73,000	$2281	$20	27	32	25	4-5	10/5	16+
Fall River	30	Medicaid Fees Comm. Blind	Not Available	Not Available	$15	30	34	17	3	6/5	16+
Lutheran	35	Private Medicaid/Fees	$73,000	$2607	$22	28	28	13	3	8/5	60+
Taunton	39	VNA Fees Medicaid	Not Available	Not Available	$16	20	32	15	3	8/5	16+
Windsor	39	State Medicaid Fees	$39,000	$2166	$20	15	18	11	4	8/5	18+
Central	96	SRS/DEA MHRH/Fees Fundraising	$250,000	$3846	$18.50	55	65	46	5	8/5	18+
Comprehen.	92	State SRS Fees	$81,000	$1620	$0-14	45	50	35	5	8/5	55+
Cranston	24	DEA	$90,000	$2570	$12	50	35	25	5	8/5	65+
Fruit Hill	96	DEA/SRS *Council on Arts/NWMH	$200,000	$5000	$20	50	40	40	3	6/5	60+
Westerly	24	Westerly Hosp DEA/SPS Private	$60,000	$2400	$2-15	20	25	13	4	9/5	18+*

*some individually considered

Staffing

The Staffing of the Centers depends on the services they offer their clients, and their affiliation with other agencies. In the State of Massachusetts the Adult Day Health Manual (407, pp. 4-7 to 4-16) specify the staffing requirements at the centers to provide the following services: Nursing, restroative, maintenance-therapy, activities, personal care, nutrition, counselling, emergency, case management and transportation. The minimum of two full-time professional staff members for each center is required. Additional personnel must be added to maintain a ration of one full-time staff member involved in direct service to participants for each six participants. Nondirect care staff, e.g., cook, accountant, secretary, etc. The qualifications and responsibilities of the required professional staff members and additional personnel are detailed in section (412).

Most of the centers meet the majority of staff requirements, however, some of them fall below these minimum requirements. The occupational background of the directors of the centers usually vary according to the nature of services offered by these centers. Among the eleven surveyed centers, five are directed by an R.N., two centers are directed by persons with masters degrees in social work or arts, the rest of the directors have different occupational backgrounds, e.g., art education, business, public health, liberal arts and planning. Centers which are not directed by a nurse, include a nurse in their staff. Most of the centers employ social workers usually on a part time basis.

Table 18: Staffing Patterns of Centers

	Director	Asst. Direct. or RN	Social Worker	Activ. Direct.	Medical Personnel	Aides	Consultants	Volunteers	Driver	Other
Barnstable	BA in art	RN	x			2c FT		x		
Dartmouth	RN FT			x PT		2c* FT	x 2/mo.			
Fall River	Admin FT	RN FT	x PT	x PT	LPN FT				x FT	
Lutheran	x FT	RN FT		x FT		1c FT		2		
Taunton	RN FT			x FT		2c FT				
Windsor	RN FT		Trainee 3-5 hrs. PT	BA in Soc. FT						
Central	MA FT	BA FT	BSW Geron.	x FT	2RN PT	4S PT			x FT	x
Compreh.	BA FT	BA EMT FT		BA PT	RN FT	1S* FT		x PT		
Cranston	RN FT	RN FT				4S PT/FT	MD PT			
Fruit Hill	RN FT		BA FT				MA PhD PT		x FT	
Westerly	MSW FT	RN FT		x FT	RN/ LPN PT					x PT

C-Clerical Aide
S-Senior Service Aide
* Physical Therapist--part time also

** Central Geriatric Center also employs an independent living skills instructor. Westerly Adult Day Care Center employs a bookkeeper.

Services

The majority of the centers offer the following services, either by their staff or through community agencies: Physical therapy, occupational therapy, client and family counseling, referral, legal, haridressing, optometrist visits, podiatrist visits, transportation if needed. One center indicated that they help clients with budgeting and/or balancing their checking accounts.

The following table describes the services offered by the centers. A word of caution as to the quality of these services: the interviewers were instructed to gather as much information as possible. Most of the directors interviewed were inclined to exaggerate the scope and quality of the services they render. As an example one of the director's response reflects great exaggeration of the services offered especially when it is indicated that all these services are offered by the center while there are no qualified staff to offer all these services. As in many evaluative studies of social services, the authors were faced with the difficulty of accurately measuring the effectiveness of these services through this exploratory study.

Table 19: Services Available to Clients at Centers

Available To Clients	Physical Therapy	Occupational Therapy	Family Counselling	Client Counselling	Tax Help	Referral Service	Legal Help	Hairdresser/ Barber	Optometrist Visit	Podiatrist Visit	Shopping Trans.	Dr. Appoint. Trans.	Visiting/Rec. Trans.
Barnstable	A*	A*	S	A	N	A	N	A*	N	N	N	S	S
Dartmouth	A	A	A	A	N	A	A*	A	N	A	N	A*	N
Fall River	A	A	A	A	A	A	A	A	A	A	A	A	A
Lutheran	A	A*	A	A	R	A	A*	A	A*	A*	S*	A*	S
Taunton	A	A	S	S	R	A	A	A	A	A	A	A	A
Windsor	A	A	A	A	N	A	A	A*	N	N	N	N	N
Central	A	A	A	A	A*	A	A	A	A	A	A	A	A
Comprehen	S*	N	S*	S*	S	S	R	A*	A	A	A	A	
Cranston	A	A	A	A	A*	A	A*	A*	A*	A*	A*	A*	R
Fruit Hill	A*	A*	A	A	S	A	S*	R*	S*	S*	S*	A*	S
Westerly	S	S	A	A	N*	A	N*	N*	S	S	S	A	R

A- Always
S- Sometimes
R- Rarely
N- Not at all

* Outside of the center

Table 20: Auxiliary Services Available Through Centers

	Emergency Phone Assurance	Weekend Meals	Holiday Meals	Check on Living Conditions	Shopping	Laundry	Doctor Visits	Visiting Others	House Cleaning	Cooking
Barnstable	YES *	YES *	YES *	YES *	YES *	YES *	YES	NO	YES *	YES *
Dartmouth	YES *	YES *	YES *	YES *	YES	YES *	YES *	NO	YES *	YES *
Fall River	YES	NO	NO	YES	YES	NO	YES	YES	NO	YES
Lutheran	YES *	NO	YES *	YES *	YES **	YES **	YES	NO	YES *	NO
Taunton	YES *	YES *	YES *	YES *	YES *	YES *	YES	YES	YES *	YES *
Windsor	NO	NO	NO	YES *	YES *	YES	YES	NO	YES *	YES *
Central	YES	NO	NO	NO	NO	YES	YES	NO	NO	NO
Comprehen.	YES	NO	YES *	YES *	NO	YES *	YES *	NO	NO	NO
Cranston	NO	NO	NO	YES	YES	YES	YES	YES	NO	NO
Fruit Hill	YES	NO	YES	YES	YES **	YES **	YES **	YES **	YES **	YES **
Westerly	NO	NO	NO	YES	YES *	YES *	YES	NO	YES *	YES *

* Outside the center
** Social Worker at center helps arrange necessary services

The services offered by some of the centers in Massachusetts are far less than what is required by the Adult Day Health Manual (pp. 7-11).

a. Transportation

The centers in the catchment area provide a variety of transportation options for their clients. The following table summarizes these options.

Table 21: Transportation Utilized

	Barnstable	Dartmouth	Fall River	Lutheran	Taunton	Windsor	Central	Compreh.	Cranston	Fruit Hill	Westerly
State/Local	0	0	3	0	62	0	0	81	0	14	78
Family	9	12	6	3	16	47	0	11	34	4	10
Public	0	0	0	84	12	0	28	4	0	0	0
Own bus	91	0	90	0	0	0	72	0	0	80	0
Other: Comm. Serv.	0	0	1	3	6	0	0	0	66	0	12
Other: Private	0	88	0	10	3	53	0	4	0	0	0

* approximation

b. Meals

The meals for the clients are prepared on site at three centers. Six adjacent agencies, e.g., nursing homes or hospitals provide meals for the clients at the centers. Only two centers provide the meals for their clients through meal sites close by the centers. All centers provide special diet meals to their clients.

One of the problems from which clients of day care centers suffer is the availability of services; e.g., food, during weekends, especially for those living alone. The majority of the centers (8) do not have any provisions for providing meals for those clients who are living alone during weekends. The meals during holidays are not part of the program of services offered by four centers. The rest of the centers (7), indicated that they refer their clients to local churches or homemaker agencies to make such provisions.

c. Families in Crisis

The majority of the centers indicated that they provide crisis intervention services for the clients through the center as well as through referral to other community agencies, e.g., nursing homes, hospitals, nursing aid agencies.

d. Clients' Short Term Illness

If a client is suffering from a short term illness, all centers have no provisions for direct services for this client. Most of the centers indicated that they would refer clients to homebound services. Three centers mentioned that they would give their clients a sickness leave from the center (!)

e. Services for Clients Living Alone

For clients living alone, many centers offer a variety of services. All centers help clients in making appointments with their physicians. The majority of centers (7) have emergency telephone reassurance services either through their own staff or community agencies. The remaining centers (4) do not offer such services.

f. Reactions of Clients to Services

The sample of clients interviewed provided some data regarding services and the degree they rely on the centers.

The majority of respondents (14/48%), rely on their families to arrange for doctors' visits, while eleven (11/38%), rely on the center for this arrangement, and the rest (4/14%) rely on self or other sources.

The respondents who needed help with their taxes indicated that they would rely on their families (11), and on the center (1).

Respondents who get sick at home rely on their families (13/45%) to take care of them, seven (24%) rely on themselves. One(3%) relies on the center, (5/17%) on agency, and (3/11%) indicated that they never get sick.

On days when respondents do not go to the centers, they stay home to relax or do cleaning (14), watch T.V. (14), walk (4), visit friends (5), and go shopping (1).

After they leave the center, respondents go to their home usually to relax, have dinner and watch T.V.

g. If Client is Living Alone

All respondents who live alone (11) cook their own meals. Some of them (4) take care of their own laundry, while four rely on homemaker aides, paid help (1) and the center (1). Some respondents (5) take care of their own shopping, while (3) rely on homemaker aides, family (2) and a friend (1). House cleaning is mainly done by respondents (7), while the rest (4) rely on homemaker aides.

h. Daily Activities

The average day at a day care center, according to the collected data, starts with the arrival of clients at the center where they are provided with coffee and a snack. Usually at 10:00 a.m. the center schedules different activites; e.g., exercises, physical therapy, and social, health and recreational events. One center offers a current events session. After lunch, clients participate in different activities until they leave about 3:00 - 4:00 p.m. Some (2) centers provide religious services almost on a daily basis. One center indicated that they offer special sessions dealing with death and dying.

Special activities for disoriented clients are provided by some centers. Some small groups are organized according to ethnic background. Also, special groups are organized for stroke patients. For alert clients, reading groups are organized.

Activities are for all clients, and there is no coerciveness in selection of activities. At large centers (4), many various activities are offered concurrently (5-10 small groups). However, in small centers, (2) there is only one activity conducted for all clients at the same time. The rest of the centers range from 2-4 groups at the same time, with two groups predominant.

All centers provide a variety of activities for their clients; e.g., plays, fashion shows, reminiscing groups, art, drama, senior olympics, sing-a-longs, square dancing, cookouts, movies, parties, holiday festivities, reading and religious activities.

Clients also participate outside the centers in picnics, fairs, scenic rides, boat rides, restaurants, church women luncheons, bowling, theatre matinee, swimming, visit museums, ballgames, bingo parties, visit senior citizens' centers, shopping. However, one center does not provide any programs outside the center. One center indicated that they ask their clients what they would like to do before they die, and fulfill it for them.

The majority (20) of respondents listed arts and crafts as their main favorite activity at the centers followed by exercises (9). Also, sitting and talking was indicated as a favorite.

i. Relationship with Families and Community Agencies

The majority of the centers (9), have direct contact with the families of residents (when applicable). If there are any problems, they are reported to the families for proper action. Most of the time, contact is made by phone. One center recently started a support group for the families. Some of the centers (4) indicated that it is difficult if the families are not supportive.

As to the relationships of centers with other community agencies, these relationships vary from one center to another. Most of the centers have relationships with emergency medical services, including transportation by

ambulance, especially if they are housed in a hospital or a nursing home. However, some of them have not yet established such a relationship. The centers depend on a variety of community agencies in providing auxiliary services for their clients. The majority of centers have established relations with nutrition, homemaker, visiting nurses and transportation agencies.

j. Discharge

Clients are discharged from day care centers mainly if they are incapable of living alone or if their families cannot take care of them any longer, or if the clients become severely ill and need hospitalization and care at a nursing home. However, some centers (4) indicated that they discharge patients if they become abusive or incontinent.

B. Reactions

a. Assets of the Centers

Directors of the centers feel that their great assets are: feelings of independence of clients, respite care for families, staff as part of a caring network, small size groups, warmth, independence, center as support to clients' families, medical care which is cost effective, prevention of unnecessary institutionalization, center for referrals, companionship for elderly, health care, nutrition, remotivation, supervision of clients, connection with network of services, individuality and independence.

b. What Do Respondents Like Most

The majority of the respondents (26) indicated that the best thing about the centers was meeting people. They also mentioned "getting out of the house" as the second best

thing that attracts them to the centers. The majority (24) of the respondents developed good relations with other participants at the centers. However, five (5), of them indicated that the participants are mere acquaintances.

c. Five Years From Now

The directors of the centers were asked how do they see their centers five years from now. The responses were: There will be greater need for day care centers and increase in public awareness, increase in space, facilities and offering services seven day per week.

d. The Type of Center: Medical vs. Psycho-social

Directors of centers were asked to identify where they would place their centers on a continuum describing their center's activities from medical (1) to psycho-social (10). Six centers identified themselves closest to psychosocial more than medical (one center 6, 2 centers 7, 3 centers 8). Three centers selected 5 which is the middle point, while only two centers felt that their services are closer to medical (one center 3, another center 4).

Categories:	Medical								Psychosocial	
	1	2	3	4	5	6	7	8	9	10
# of centers			1	1	3	1	2	3		

e Problems of Centers

Many centers indicated that the problems they are currently facing are: funding, transportation and lack of staff, space and facilities. One remark made by all centers connected to nursing homes is the stigma attached to nursing

home and how it affects the day care center's clients.

f. Problems of Clients

When respondents were asked about any problem they might have, the general response was no. However, when probed, some of the problems listed were lonesomeness, money, health, lack of physical therapy in some centers, feeling depressed, and not having anything to do during weekends. Most of the respondents spoke highly of the services offered by the centers, and how these centers are helping them.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The data clearly raises many issues of importance. In this chapter an attempt will be made to review some of these issues as well as to explore some answers for the questions we suggested at the outset of this study.

Standards and Regulations

One of the important issues is the fact that the State of Massachusetts was successful in the development of a set of guidelines and requirements for the establishment and functioning of daycare centers so their clients may be eligible for Medicaid reimbursement. (All the six centers in the catchment area in the State of Massachusetts are eligible). There are no similar provisions in the State of Rhode Island. A bill introduced in Rhode Island in 1980 failed to pass to organize daycare centers so their clients would be eligible for Medicaid payments.

The Massachusetts guidelines will be utilized in data analysis particularly in reference to the centers located in that State.

Criteria and Processes for Admission

Each of the centers in the catchment area, in both States, developed their own criteria for selection and admission of clients. An attempt will be made to identify some of the criteria used and their implications.

a. Living Conditions

The data indicate that all centers in both States admit clients regardless of their living conditions, i.e., living alone, with family, friends, relatives or in community agencies. In average a large percentage (41%) of the clients of the centers in the catchment area live alone. This raises an important issue. If day care centers are willing to

accept that large number of clients living alone, and certainly they should, they must be aware of the implications. Wan and Weissert (1) draw our attention to these implications. "The findings of this analysis indicate that the social support networks have a positive effect on patient status at the end of the day care and homemaker experiment and that the availability of siblings, other relatives and neighbors as sources of social support is associated with high levels of physical and mental functioning. Institutionalization, as measured by the likelihood of being institutionalized in a skilled nursing facility and by the likelihood of being hospitalized in a short-term stay hospital, was found to have a strong relationship to "living alone". A more careful causal analysis of institutionalization might reveal the determinants and consequences of living alone not detected in this study.

The availability of children or other relatives among the survivors of the follow-up sample was shown to have a positive effect on reduction of risk of being institutionalized in a skilled nursing facility, but it had no effect on hospitalization. Living alone and lack of strong social support networks might have a synergistic effect on the risk of being institutionalized in SNFs. Those individuals who have a greater need for assistance in the activities of daily living when their physical and mental health fails, and who lack opportunities to receive alternative modes of ambulatory geriatric services are more likely to use institutional care, especially nursing homes.

Centers then should be able to provide the needed supportive system to this group of clients. The data suggest that some centers neither have the staff nor the facilities to provide these services. This is a serious

shortcoming since one of the dangers of such a phenomenon is the bureaucratic attitude that would lead to the belief that clients need services only during the working hours of these agencies. This is a gross mistake. The elderly will not be put on hold after working hours or during holidays!

This principle does not apply only to clients living alone. The responsibility of the centers in general is to see to it that the basic biological and psychological needs of clients are well met through the centers or other community agencies. Centers should extend their services beyond the confines of their building and beyond their working hours.

b. Age

Age as a criterion for admission varies among centers from 16 to 65. The age mix of clients at centers which accept persons 16+ may have some implications. This area needs to be explored to identify the feasibility of rendering services at the centers with this degree of heterogeneity among the clients. Centers with lower age criterion for admission (16+) should be aware of the implications. Centers of this nature (four 16+ and two 18+ in the catchment area) will be considered as centers for handicapped and frail adults, not particularly elderly. The authors at this point are sure that this might have many implications on the structure, functions, services, activities and staffing of these centers. Their inclination is that it would affect the whole concept of day care centers for the elderly as it is understood to be.

The State of California in its "California Adult Day Health Care Act". Assembly Bill No. 1611, defines "elderly" or "older person" as a person 55 years of age or older, but also includes other persons who are chronically

ill or impaired and who would benefit from adult day health care. No definition is provided to indicate the age of "other" persons. Both States, Massachusetts and California developed the guidelines to make provision for clients to be covered by the Medical Assistance Program. This might be the reason for centers not to set old age restriction as a criterion. However, it is the prerogative of any center to set a minimum age limit as a criterion for admission. An example of such a center is Windsor Adult Day Center in Massachusetts which preferred to set a minimum age of over 60 as a rule. The Director of the center explained that it is more appropriate to set this age limitation due to the wide gap in services created by age mix.

It is highly recommended that:

(1) The Southeastern Long Term Care Gerontology Center should study the implications of age mix of clients at daycare centers whose criteria is 16+. This study should be geared to identify the impact of such an arrangement on the structure, functions, services, activities, and staffing of these centers.

(2) Centers should be encouraged to gear their services either to elderly or to young adults who are physically impaired. This would be more appropriate and functional.

c. Quality of Services

Centers vary considerably as to the criteria they use for admitting impaired clients. This variation is due to many factors; e.g., the facilities at the center, available services at the agency to which the center is attached, available qualified staff, and the lack or presence of community supportive systems. If we consider the main three factors. (1) degree of various types of impairment, (2) direct services

offered by the center, and (3) qualifications of staff. many serious questions could be raised as to the quality of services many centers reported they offer.

Regardless how many clients are registered at a center, quality service depends on the qualifications of the staff and the degree to which they are eligible to perform the services they claim to render at the centers. As an example the Director of one of the centers reported that the center ALWAYS provides all the services on site. In reviewing the staff qualifications and number, one would greatly doubt the quality of services offered.

Day Care Centers and Long Term Care

One of the major thrusts of this study is to identify the relationship between day care centers in the catchment area and the network of long term care services.

The data suggest that there is a clear identification of day care centers as an integral part of the network of long term care services. It fills in a gap by providing services to clients who need such services.

However, there are some questions pertaining to the relationship between day care centers and institutionalization. Adult day care centers have been considered as an alternative to institutionalization. A controlled experiment involving 1,871 patients was mounted in six locations throughout the nation to study this assumption as well as others. (2) The results of this experiment were disappointing. Day care had no statistically significant effect on nursing home entry or length of stay in nursing homes. Moreover, the rate of use of nursing homes was so low in the control group that it showed that even if day care had

been effective, it could not have prevented much use because only 21 percent of control group patients used a nursing home and their average length of stay was 1.3 months.* These figures show that the population served was similar to the elderly population in general rather than those who were at special risk. In other words, most patients (79 percent) used day care as an add-on to existing services rather than as a substitute for nursing homes. This tended to raise costs considerably rather than lower them because nursing home rates did not go down while day care cost were added anew. Put another way, $637,631 was spent on day care to prevent $37,397 in nursing home costs. (In the 3 years after the study ended, rates of institutionalization were even lower in both the treatment and control groups, 13 percent per year, and again day care use during the treatment period had no effect during the post-treatment period.)

Nor were there substantial health care benefits for the patients. Day care showed no statistically significant impact upon death rates, physical or mental functioning ability of patients, their social activity level, contentment, or the frequency of their interactions with a social support system comprised of friends and family.

Weissert (3) in discussing the attempts to find alternatives to institutions suggests that the name of the movement should be changed from "alternatives to institutional care" to "alternatives in long-term care." This suggests that the emphasis should be on providing appropriate care regardless of whetehr or not the patient is at risk of institutionalization. This approach begs the question, however, since appropriate care should mean (if nothing else) care which does some good (e.g., resulting in reduced institutionalization, better physical or mental functioning, or

* Nursing home use in the control group shows what would be expected in the treatment group in the absence of day care.

better contentment. Findings of minimal or no difference in outcomes between groups which got the care and those which did not suggest that although it was expensive, in the case of day care and homemaker services, it was at best minimally efficacious even when homemaker services led to hospitalization.

The problem then, is how to ensure either that alternatives provide beneficial impacts on health status or that they reduce costs by affecting a substitution of cheaper for more expensive care. This is a selection problem. The answer is to target alternatives as new ways of serving the same patients now being served versus using alternatives as new ways of serving an entirely new client group: one is a technical decision; the other a political one.

The authors agree with Weissert's position and feel that the issue of alternatives to institutionalization may not apply to day care centers. The service is needed to be added to the wide spectrum of long term care services. As a concept it is sound and valid. Our concern should be with the applications and implications.

Links and Relations:
An Identity Crisis

The data suggest a continuum of relations between long term care centers and other institutions and agencies in the community. In some instances these relationships are at minimum. It seems that the initial process of establishing day care centers has an impact on the final shape of its structure, functions, and identity. As previously indicated both clients as well as directors of some of the day care centers attached to nursing homes indicated their concern that the stigma impedes the development of a healthy image of day care centers. As much as some administrators of these nurs-

ing homes feel that the day care center is a natural extension of the nursing home. This leads to confusion and an identity crisis. The reluctance of some administrators to identify the budgets of the centers lead us to believe that in some cases the integration of the staff and services of both the nursing home and the day care center is an impediment to the development of a sound and valid structure. The implications are not only internal, they are external as well. Community agencies relate to the (mother) agency more than to the born child; the day care center. If the concept of day care center for the elderly is sound and valid, and certainly it is, then it has to find its own identity as a free standing agency. It has to separate itself from the day hospital model, which is the origin of what is now in existence. It does not have to attach itself physically and functionally to any agency in the community. It should relate to all agencies in the community on basis of mutual concerns and functions. We should learn from the Levindale experiment which proved that the mere existence of a staffed physical facility does not warrant a successful added on function.

The relationships between the daycare centers and community agencies are vital to the success of these centers in serving the elderly population. The basic concept of twenty four hours per day service cannot be achieved without reliance on community agencies. These relationships should be structured and formalized, especially for the group of clients who are living alone in the community. The centers should provide the all needed services on continuous basis regardless of working or non-working days.

Relationships with families are essential for the maintenance of the supportive systems of clients. There are many areas of concern regarding the well being of the clients. The responsibilities of the center have to be shared with the families in the community. This relationship has to be well structured and forma-

lized.

Recommendations

The surveyed centers in the catchment area are an integral part of the long term services network. They are, with no doubt, rendering effective services to a group of clients who are in need of these services. This study explored the concept, structure and functions of these centers as they relate to the continuum of long term care services.

The Southeastern New England Long Term Care Gerontology Center (SNELTCGC) should recognize its vital role in providing leadership and direction to these centers. These recommendations are made for further consideration and action:

1. SNELGC should play an advocacy role in the State of Rhode Island to develop a set of standards and regulations for the centers and possible Medicaid coverage for their clients.

2. SNELGC should identify and reinforce the linkages between the components of long term care services. Day care centers in particular need to develop these linkages within the community on a structured basis. At the moment most of the centers are serving less than their capacity. This probably is a common problem as suggested by Weissert (4), also by some centers' directors who indicated the difficulty of recruiting clients especially those who are living alone. The development of linkages may help in alleviating this problem and maximize utilization of these vital resources.

3. SNELGC should play the role of a catalyst among long term care agencies. In the area of day care centers it is vital to develop a mechanixm through which information, concerns, problems and alternatives are shared and discussed.

5. SNELGC should develop a mechanism for the development of public forums to inform the public about all services available to them.

6. SNELGC should allocate funds to conduct more research in these areas:

    a. Needs assessment for day care services in the catchment area

    b. Linkages among the components of long term care agencies and institutions

    c. Programming of services and activities at day care centers.

References

(1) Thomas T. Wan, and William G. Weissert, Social Support Networks, and Institutionalization, Paper presented at the Annual Meeting of the APA meeting, 1980, Detroit, Mich.

(2) William G. Weissert, Toward a Continuum of Care for the Elderly: A Note of Caution, Paper presented at the APA meeting, 1980, Detroit, Michigan, pp. 3-4.

(3) Ibid. p. 6

(4) Ibid. pp. 2-6

APPENDICES

Appendix 1: Letter to Centers in Catchment Area to Inform them about Study

Appendix 2: Interview Schedules for Directors of Centers and Clients

Appendix 3: List of Day Care Centers within Catchment Area

Appendix 4: Adult Day Health Manual, The Commonwealth of Massachusetts, 1980

DAY CENTERS WITHIN CATCHMENT AREA

BARNSTABLE COUNTY HOSPITAL ADULT DAY CENTER
County Road
Pocasset, Mass. 02559
(617) 563-5941

Program Director: Connie Tullock
Date Started: January, 1976
Sponsoring Organization: Barnstable County Hospital
Funding Sources: Title XIX; participant payment; VA reimbursement; reimbursement from Connecticut General Insurance Co.; private donations
Nature of Program: Maintenance/Restorative
Average Daily Census: 15

DARTMOUTH ADULT DAY CENTER
567 Dartmouth Street
Dartmouth, Mass. 02748
(617) 997-0796

Program Director: Janet C. Gracia
Date Started: June, 1978
Sponsoring Organization: Dartmouth House Nursing Home
Funding Sources: Title XIX; participant payment
Nature of Program: Maintenance/Restorative
Average Daily Census: 25

FALL RIVER ADULT DAY CENTER
1748 Highland Avenue
Fall River, Mass. 02720
(617) 675-1131

Program Director: Jane Johnson
Date Started: May, 1979
Sponsoring Organization: Fall River Nursing Home
Funding Sources: Title XIX; participant payment; Massachusetts Commission for the Blind

Nature of Program: Maintenance/Restorative
Average Daily Census: 22

LUTHERAN GERIATRIC DAY CARE PROGRAM
888 North Main Street
Brockton, Mass. 02401
(617) 587-6556
Program Director: Marlene Farrell
Date Started: January, 1979
Sponsoring Organization: Lutheran Nursing Home of Brockton; Lutheran Services Assoication of New England, Inc.
Funding Sources: Title XIX, participant payment; OAA
Nature of Program: Maintenance/Restorative
Average Daily Census: 15-16

TAUNTON ADULT DAY HEALTH CENTER
176 Somerset Avenue
Taunton, Mass. 02780
(617) 823-4493
Program Director: Mary Powers
Date Started: September, 1978
Sponsoring Organization: Taunton Visiting Nurse Association
Funding Sources: Title XIX; participant payment; support from civic organizations
Nature of Program: Maintenance/Restorative
Average Daily Census: 14 (approx.)

WINDSOR ADULT DAY CENTER
265 North Main Street
South Yarmouth, Mass. 02664
(617) 394-3514
Program Director: Pat Trempelas
Date Started: September, 1978
Sponsoring Organization: Windsor Nursing and Retirement Home

CENTRAL GERIATRIC DAY CARE CENTER, INC.
P.O. Box 7069
Warwick, RI. 02886
(401) 739-2828

Program Director: Aldrich Trott
Date Started: September, 1973
Sponsoring Organization: Warwick Central Baptist Church
Funding Sources: Participant payment; philanthropic subsidy; private donations; fund raising; R.I. State Legislature; Title XX
Nature of Program: Maintenance/Restorative
Average Daily Census: 46 (approx.)

COMPREHENSIVE DAY CARE
99 Hillside Avenue
Providence, R.I. 02903
(401) 351-4750

Program Director: Sharon Rice
Date Started: April, 1974
Sponsoring Organization: Jewish Home for the Aged
Funding Sources: Participant payment; in-kind support from the Jewish Home for the Aged; grant from R.I. State Legislature; Title XX
Nature of Program: Maintenance
Average Daily Census: 30 (approx.)

CRANSTON SENIOR CITIZEN DAY CARE CENTER
546 Budlong Road
Cranston, R.I. 02920
(401) 461-1600, x 243

Program Director: Iza Megnanimi
Date Started: October, 1977

Sponsoring Organization: Cranston Community Action Program
Funding Sources: HUD Community Development Block Grant; participant payment; Title XX; fund raising activities
Nature of Program: Social/Maintenance/Restorative

FRUIT HILL DAY CENTER FOR ELDERLY
399 Fruit Hill Avenue
North Providence, R.I. 02911
(401) 353-5805

Program Director: Sister Ruth Crawley F.M.M.
Date Started: October, 1973
Sponsoring Organization: Franciscan Missionaries of Mary
Funding Sources: Participant payment; Title XX; Franciscan Missionaries of Mary; R.I. Department of Elderly Affairs
Nature of Program: Maintenance/Restorative
Average Daily Census: 40

WESTERLY ADULT DAY CARE CENTER, INC.
221 Post Road
Westerly, R.I. 02891
(401) 322-1613

Program Director: Susan Weisenfelder
Date Started: June, 1980
Sponsoring Organization: private, non-profit organization
Funding Sources: Participant payment; philanthropic subsidy; private donations; Title XX; R.I. State Legislature (D.E.A.); Town of Westerly grant; Geriatric Adult Day Care
Nature of Program: Maintenance
Average Daily Census: 25 (anticipated)

Southeastern New England Long Term Care Gerontology Center
Box G Brown University Providence, Rhode Island 02912 Tel. 401 863-3211

March 2, 1981

Sylvia Zaki, Professor
Rhode Island College
600 Mt. Pleasant Avenue
Providence, RI 02908

Dear Prof. Zaki:

Here is a listing of the boundaries of the catchment area included in Southeastern New England.

All of Rhode Island

HSA Region V in Mass. includes:

Old Colony Elderly Services, Inc. 430 South Main Street Cohasset, MA 02401	Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, E. Bridgewater, Easton, Halifax, Hanover, Hanson, Kingston, Lakeville, Marshfield, Middleboro, Pembroke, Plymouth, Plympton, Rockland, Stoughton, Wareham, W. Bridgewater, Whitman
Bristol County Home Care, Inc. 248 Tucker Street Fall River, MA 02721	Attleboro, Berkley, Dighton, Fall River, Freetown, Mansfield, No. Attleboro, Norton, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Westport
Coastline Elderly Services, Inc. 13 Welby Road New Bedford, MA 02745	Acushnet, Dartmouth, Fairhaven, Gosnold, Marion, Mattapoisett, New Bedford, Rochester
Elder Services of Cape Cod and the Islands, Inc. 658 Main Street W. Yarmouth, MA 02673	Barnstable, Bourne, Brewster, Chatham, Chilmark, Dennis, Eastham, Edgartown, Falmouth, Gay Head, Harwich, Mashpee, Nantucket, Oak Bluffs, Orleans, Provincetown, Sandwich, Tisbury, Truro, Wellfleet, West Tisbury, Yarmouth.

If you have any further questions feel free to contact us.

Sincerely,

D L Spence

Donald L. Spence, Ph. D.
Director

Rhode Island College
Providence, Rhode Island 02908
Established 1854

Gerontology Program

May 14, 1981

Dear

The Southeastern New England Long Term Care Gerontology Center has awarded Rhode Island College Gerontology Center a grant to study "day care as a long term service" within the center's catchment area. Some objectives of this study will be to study the history of the development of day care centers in the region, to identify the population they serve, to analyze the Center's structures and functions, to survey sources of funding, to explore the existing problems facing these centers and mainly to identify the relationship of day care centers to the long-term care network of services.

For that purpose I am sending this letter to you, hoping that you will help us conduct this study. One of the phases of the study is the survey of all existing day care centers in the catchment area. This would be achieved through the following:

(1) Collecting all needed data from different day care centers pertaining to the objectives previously cited.
(2) Site visits to further explore the objectives of the study.

I would certainly appreciate your support by sending us any literature or information you may have about your center which would help us achieve our objectives. This material will be studied by our staff who will arrange the site visit with you.

I sincerely appreciate your cooperation in this matter and hope that I receive this material at your earliest convenience.

Sincerely yours,

Sylvia Zaki

Mrs. Sylvia Zaki
Assistant Professor
Coordinator, Outreach Programs

SZ/clm

R.I. College

Gerontology Center

Day Care as a Long-Term Care Service Study

Interview Schedule

Part 1

Dr. Gamal Zaki

Ms. Sylvia Zaki

Funded through the
Southeastern New England Long Term Care Gerontology Center
Brown University

by

The Administration on Aging
Older Americans Act Title IV E
90 AT-2164

DAY CARE CENTERS STUDY

Day Care Center: _____

Address: _____

Director: _____

Building: (free-standing____, connected to a hospital____, nursing home____, community center____, other (specify)_____.)

Accessibility to handicapped: _____

_____

1. How was your program developed?

   a. Year _____

   b. By whom and how did the program start?

   _____

   _____

   _____

   _____

   c. Original funding and funding Provisions to date:

   _____

   _____

   _____

   _____

   _____

   _____

   d. Physical Facilities: (where did the program start; any changes? Additions to physical facilities?)

   _____

   _____

   _____

   _____

   _____

e. Was it a spin off from another program? (multipurpose center, hospital?) Explain.

_____

_____

_____

_____

2. What hours are you open? What days? Which holidays are you closed?

a. Daily hours: _____

b. Days open: _____

c. Closed on these days during the year:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

3. How large is your facility? (In case the Day Care Center is part of another program or facility, the response should pertain only to those facilities used only for the purpose of the Day Care Center.) Do you have special rooms for the following?

	For the Center	Shared With Other Person
Dining		
Kitchen		
Resting		
Nursing (bed baths)		
Counseling		
Physical Therapy		
Recreation		
Other: (Specify)		

4. Does your center have close access to a hospital or emergency room? In what way?

_____

_____

_____

_____

5. Do you have any service relationship with other agencies in the community? (Be very specific.) What relationship exists, what services are consequences of each relationship, how often and who pays? (list all of them.)

	Name of Agency	Services	How Often	Who Pays
a.				
b.				
c.				
d.				
e.				
f.				

6. a. How is your program funded? (All sources, including in-kind.)

	Source	Average Yearly Amount
(1)	_____	_____
	_____	_____
(2)	_____	_____
	_____	_____
(3)	_____	_____
	_____	_____
(4)	_____	_____
	_____	_____
(5)	_____	_____
	_____	_____

b. What is your yearly average total budget?

_____

c. Is there any way we could have a copy of your yearly budget?

Yes ___ No ___

d. Percentages of expenditures

(1) _____% Personnel

(2) _____% Capitol

(3) _____% Operation

(4) _____% Miscellaneous

7. Do you provide services to any state or local programs?

a. _____

_____

b. _____

_____

c. _____

_____

8. Who comprises all of your staff? What are their qualifications? What are their responsibilities? Do they work full or part time?

	Staff*	Qualifications	Main Responsibilities	FT	PT
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					

* e.g., Director, Assistant Director, Social Worker, Nurse, Aides, etc.

9. a. What is your client capacity; i.e., how many clients can you accommodate at one time?

_____

b. What is your average daily census?

_____

c. How many clients are registered?

_____

d. Do you have a waiting list?

_____

How many? _____

10. a. Are the majority of your clients from any particular ethnic group? (% of different groups serviced.)

_____

_____

_____

b. Does this show up as an asset or an impediment to your program?

_____

_____

_____

c. Does this have any bearing on services or activities?

(1) Recreation: _____

_____

(2) Health Maintenance: _____

_____

(3) Food: _____

_____

(4) Ethnic festivities and holidays: _____

_____

(5) Religious services: _____

_____

(6) Medications: _____

_____

(7) Other (Specify): _____

_____

_____

_____

_____

11. In general, what is your average weekly frequency of attendance of a client?

_____

12. Who refers clients to you? Rank from most frequent to least frequent.

a. _____

b. _____

c. _____

d. _____

e. _____

13. What criteria do you use in selecting and accepting your clients?

a. Living Conditions: i.e., alone or with family or friends or in institutions, marital status, etc.

_____

_____

_____

b. Economic Conditions: _____

_____

_____

c. Age: _____

_____

_____

d. Catchment Area: _____

_____

_____

e. Other (Specify): _____

_____

_____

14. Is there any category of impairment that you will not accept? (Please describe degree of category, severe to mild, where appropriate. Put CNA for client not accepted.)

	Very Severe	Severe	Mild	Very Mild
a. Incontinence	_____	_____	_____	_____
b. Homicidal	_____	_____	_____	_____
c. Suicidal	_____	_____	_____	_____
d. Alcoholism	_____	_____	_____	_____
e. Handicapped*	_____	_____	_____	_____
f. Rely on walker	_____	_____	_____	_____
g. Retarded	_____	_____	_____	_____
h. Depressed	_____	_____	_____	_____
i. Disoriented	_____	_____	_____	_____
j. Schizophrenic	_____	_____	_____	_____
k. Paranoid	_____	_____	_____	_____
l. Any other mental disorder	_____	_____	_____	_____
m. Other (Specify):				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

* Could not move without wheelchair

15. Prior to acceptance, is there a personalized assessment of the client?

a. Medical history and admission form by M.D.

b. Needs assessment (physical) (By whom? At the Day Care Center or from outside? Or both? Please specify.)

c. Needs assessment (psycho-social) (By whom? At the Day Care Center or from outside? Or both? Please specify.)

d. Living conditions of client (Case study of client) (By whom? At the Day Care Center or from outside? Or both? Please specify.)

e. Interview family, relatives, etc. (People with whom client lives) (By whom? At the Day Care Center or from outside? Or both? Please specify.)

16. Upon acceptance, do you conduct orientation for:

a. The client (Please describe in detail):

b. The family (See definition in 15-e. Please describe in detail):

17. a. Do you have individualized treatment plans for each client? (Please describe provisions of planning process.)

(1) Medical: (Medication and physical therapy included.)

(2) Diet:

(3) Psycho-social: (Counseling client and family included.)

b. Is this information shared by all staff and family members. How? (Staff meetings? How often? Please describe in details.)

_____

_____

_____

_____

18. With whom do your clients live? Give percentages (approximate).

a. Spouse _____

b. Children _____

c. Relatives _____

d. Friends _____

e. Alone _____

f. Institution _____

g. Other (Specify)

_____ _____

19. Do you have any beds available on a daily basis? How many?

_____

20. What kind of transportation do you rely on? (Approximate percentage of clients using each.)

a. State or local transportation (Senior Citizen Transportation) ____%

b. Family ____%

c. Public Transportation ____%

d. Own bus (what is capacity? _____) _____%

e. Other (Specify): _____ ____%

_____ ____%

21. Does your center have access to a congregate meal site or do you prepare meals for your clients?

_____

_____

22. Are there special meals available for those on special diets? (For both meal site or onsite.) Describe.

23. When does the center find it necessary to discharge a client? (Reasons and conditions) Where are they referred to and by whom? Describe in detail.

24. a. If the client is living with someone, what kind of relationship is maintained with the person with whom they are living? Can you cite some examples please.

b. What happens if the family (see definition in 15-e) is in a crisis?

c. What if they go on vacation? What provisions are made, if any, for your client?

d. What if the client has a short-term illness?

_____

_____

_____

25. For those who live alone, are any of the following provisions made available by your Center or by another agency?

	No	Yes	If yes, by whom
a. Emergency telephone assurance	___	___	_____
b. Weekend meals	___	___	_____
c. Holiday meals when Center is closed	___	___	_____
d. Check on living conditions	___	___	_____
e. Help with:	___	___	_____
(1) Shopping	___	___	_____
(2) Laundry	___	___	_____
(3) Doctor visits	___	___	_____
(4) Visiting others	___	___	_____
(5) House cleaning	___	___	_____
(6) Cooking	___	___	_____
(7) Other (Specify)			
_____	___	___	_____
_____	___	___	_____

26. Whenever needed, do you provide any of the following services? How often? Who does it?

	Always	Sometimes	Rarely	Not At All	Service Offered By: Center Staff	Community Agencies	Client Takes Care Of Service
a. Physical therapy							
b. Occupational therapy							
c. Family counseling							
d. Client counseling							
e. Tax help							
f. Referral service							
g. Legal help							
h. Hairdresser/barber							
i. Optometrist visit							
j. Podiatrist visit							
k. Transportation for shopping							
l. Transportation for doctor's appointments							
m. Transportation for visiting or recreation							
n. Other (Specify):							
_____							
_____							

-14-

27. Is there a special procedure for clients to have visitors during the day? (e.g., family members, friends, etc.)

28. Could you give examples of some special programs, other than everyday activities, that have been run at your center? Were these provided by outsiders or staff?

29. Can you tell about any special programs outside the center where your clients participate? (On-hours or off-hours)

30. a. What are the rates of your Center?

b. What is the process and procedure for deciding individual rates?

31. Could you give an example of an average day for the clients at your center? Please be very specific; if programs, what are they?

32. If there is an activity being conducted, do all the clients participate?

a. What activities are for <u>all</u> clients?

b. What activities are for special groups of clients or individuals?

33. How many activities are being conducted concurrently at your Center? Please specify.

34. On this continuum, where would you place the majority of your clients at this time?

1	2	3	4	5	6	7	8	9	10
Active									Frail

35. On this continuum, where would you place the Center's activities?

1	2	3	4	5	6	7	8	9	10
Medical									Psychosocial

36. What, in your opinion, are the assets of your Center?

37. What, in your opinion, are the problems of your Center?

38. What, in your opinion, will the Center be in five years from now?

R.I. College

Gerontology Center

Day Care as a Long-Term Care Service Study

Interview Schedule

Part 2

Dr. Gamal Zaki

Ms. Sylvia Zaki

Funded through the
Southeastern New England Long Term Care Gerontology Center
Brown University

by

The Administration on Aging
Older Americans Act Title IV E
90 AT-2164

CLIENT QUESTIONNAIRE

Background Data: (Either from client or records, depending on condition of client.)

1. Age:
   (a) 65-70 ___
   (b) 71-75 ___
   (c) 76-80 ___
   (d) 81 or over ___

2. Sex:
   (a) Male ___
   (b) Female ___

3. Marital Status:
   (a) Never married ___
   (b) Married ___
   (c) Separated or divorced ___
   (d) Widowed ___

4. Ethnic Background:

   _____

   _____

   _____

   _____

5. Highest level of education attained :
   (a) None ___
   (b) Grade school ___
   (c) High school ___
   (d) Vocational or trade school ___
   (e) Some college ___
   (f) Completed college ___
   (g) Graduate school ___

6. What was your main occupation:
   (a) Unemployed most of the time ___
   (b) Machine operator, deliveryman, bartender, waitress, truck driver ___
   (c) Foreman, electrician, typographer, carpenter, plumber, hair dresser, skilled manual worker ___
   (d) Secretary, administrative assistant, factory supervisor, sales clerk, laboratory technician ___
   (e) Owner/executive of small business, real estate agent, insurance examiner, sales representative, buyer ___
   (f) Teacher, executive of middle-size business, manager, nurse, physiotherapist, social worker ___
   (g) Doctor, lawyer, executive of larger corporation, accountant, engineer, journalist, clergyman, college professor ___
   (h) Housewife ___

7. Duration of joining Day Care Center: Years _____ Months _____

8. Where do you live:
   (a) With spouse ___
   (b) With family ___
   (c) With friends ___
   (d) Alone ___
   (e) Institution ___
   (f) Other (Specify) _____

9. How did you hear about the Center?

_____

_____

_____

10. Have you been admitted to a hospital within the last 5 years?
    Yes ___ No ___

    If yes,

11. Indicate nature of illness: _____

_____ _____ _____

_____ _____ _____

12. Are you on regular medications? Yes ___ No ___

    If yes,

13. Do you need help in administering these medications? Yes ___ No ___

14. Do you have any difficulty dialing the telephone?
    (a) No ___
    (b) Sometimes ___
    (c) All the time ___

15. Do you have any difficulty reaching for objects in high places?
    (a) No ___
    (b) Sometimes ___
    (c) Yes ___

16. Do you have any difficulty in picking up objects from the floor?
    (a) No ___
    (b) Sometimes ___
    (c) Yes ___

17. Are you able to cut your food?
    (a) Yes ___
    (b) Sometimes ___
    (c) No ___

18. Do you use a wheelchair, cane, or walker?
    (a) Neither ___
    (b) Either walker or cane ___
    (c) Wheelchair ___

19. Are you able to walk up and down steps without difficulty?
   (a) No difficulty ___
   (b) Difficulty only walking up steps ___
   (c) Difficulty walking both up and down steps ___

20. Do you have any problem rising from a chair or bed?
   (a) No difficulty with either ___
   (b) Difficulty in getting out of bed ___
   (c) Difficulty in getting out of bed and chair ___

21. Do you have dizzy spells?
   (a) None of the time ___
   (b) Occasionally ___
   (c) Frequently ___

22. Do normal everyday activities cause you to become fatigued?
   (a) No tiring ___
   (b) Tires on exertion ___
   (c) Feels tired most of time ___

23. How many times within the last year have you had a cold or the flu?
   (a) Never ___
   (b) Two or three times ___
   (c) Five or more ___

24. Have you ever smoked?
   (a) Never ___
   (b) Used to smoke, but has stopped ___
   (c) Has smoked for five years and continued smoking ___

25. Do you use any hearing device?
   (a) No device needed ___
   (b) Yes and device helps ___
   (c) Yes, but still have difficulty ___

26. Do you wear glasses or contact lenses?
   (a) None worn, vision good ___
   (b) Yes and lenses are corrected properly ___
   (c) Yes, but still have difficulty seeing ___

27. When did you last have an eye examination?
   (a) Within last year ___
   (b) More than a year ago ___
   (c) Never ___

28. Would you change any of your life?
   (a) No, generally happy with it ___
   (b) Would change some aspects of life ___
   (c) Exhibits anger about life and would have changed it if had the opportunity ___

29. Do you have any physical complaints?
   (a) Occasional complaint ___
   (b) Has several physical complaints ___
   (c) Continues to discuss variety of physical complaints ___

30. Do you read the newspaper?
    (a) Usually everyday ___
    (b) On occasion, Sunday paper only ___
    (c) Not at all ___

31. Do you watch TV or listen to the radio?
    (a) Daily ___
    (b) Occasionally ___
    (c) Not at all ___

32. Do you see or hear from friends?
    (a) Yes, I visit ___
    (b) Yes, I talk on the telephone ___
    (c) No, they are all gone ___

33. Are you able to do your own shopping ?
    (a) Yes ___
    (b) Sometimes ___
    (c) No ___

34. On average, how many days per week do you come to the Day Care Center?

    _____

35. What transportation do you use? (If more than one, please prioritize)
    (a) Own ___
    (b) Family ___
    (c) Public transportation ___
    (d) Senior Citizen transportation ___
    (e) Center's bus ___
    (f) Other (Specify) _____

36. Are you on a special diet? Yes ___ No ___
    If yes, describe briefly:

    _____

    _____

37. What do you usually do at the Center? (List all activities exactly as indicated by the client and in the same order.)

    (a) _____

    (b) _____

    (c) _____

    (d) _____

    (e) _____

    (f) _____

    (g) _____

38. What activities do you like most at the Center? (List according to response.)

(a) _____

(b) _____

(c) _____

(d) _____

39. If you have a personal problem, with whom would you discuss it?

_____

_____

_____

40. If you need some help to do some personal errands, where do you seek help?

_____

_____

_____

41. If you need to visit your doctor(s), who would arrange for these visits?

_____

_____

_____

42. If you need help with your taxes, whom would you seek for help?

_____

_____

43. If you are sick at home, what do you do? (Indicate if living alone or with other persons, and what help they offer, if any.)

_____

_____

_____

_____

_____

44. What do you usually do (<u>activities</u>) on the days you do not come to the Center?

_____

_____

(More space to answer on next page)

44. (Continued) _____

_____

_____

45. What do you usually do after you leave the Center?

_____

_____

_____

_____

_____

IF CLIENT IS LIVING ALONE:

46. Who cooks your meals at home?

_____

_____

47. Who takes care of your laundry?

_____

_____

48. Who takes care of your shopping?

_____

_____

49. Do you have any help with house cleaning?

_____

_____

50. In case of emergency, whom do you call?

_____

_____

51. Do you have friends in the area where you live? (Please indicate how many? similar age? able to help?)

TO ALL CLIENTS

52. Do you have any problems? (Probe. Identify if Center is helpful or not?)

53. Do you have any friends at the Center? (Probe.)

54. What do you like most about the Center? (Probe.)

55. Thanks. Any comments?

OBSERVATIONS

1. Observation of level of consciousness:
   (a) Alert, responsive ___
   (b) Semi-responsive ___
   (c) Unresponsive ___

2. Observation of dress:
   (a) Neatly dressed, colors coordinated, somewhat with current fashion ___
   (b) Neatly dressed, colors not coordinated, out of style ___
   (c) Inappropriately dressed ___

3. Observation of male client:
   (a) Clean shaven ___
   (b) Has not shave for a day ___
   (c) Has not shaved for an extended period ___

4. Observation of female client:
   (a) Wears make-up appropriately ___
   (b) Slightly inappropriate use of make-up ___
   (c) Drab, dull appearance ___

5. Observation of expression of affect:
   (a) Generally happy ___
   (b) Blase ___
   (c) Appears sad, despairing ___

6. During interview, did client express:
   (a) Feelings of interest, satisfaction, joy ___
   (b) Feelings of doubt ___
   (c) Feelings of helplessness/hopelessness ___

7. During interview did client exhibit:
   (a) Concentration and understanding of discussion ___
   (b) Slowness of thought ___
   (c) Inability to make decisions/inability to concentrate ___

8. Observation of client. Does he appear:
   (a) Confident and secure ___
   (b) Somewhat insecure ___
   (c) Withdrawn ___

9. During interview did client:
   (a) Give responses without hesitation ___
   (b) Give responses with some hesitation ___
   (c) Have difficulty responding to questions ___

The Commonwealth of Massachusetts
Department of Public Welfare
600 Washington Street, Boston 02111

MEDICAL ASSISTANCE PROGRAM
TRANSMITTAL LETTER ADH-1
January 1980

TO: Adult Day Health Providers Participating in the Medical Assistance Program

RE: Adult Day Health Manual

The regulations of the Department of Public Welfare (including the conditions of participation) concerning provider participation in the Medical Assistance (Medicaid) Program are being published in a new format, the Provider Manual Series. This transmittal letter establishes the Adult Day Health Manual. This manual will eventually contain administrative regulations, billing regulations, program regulations, and billing instructions, information that is essential for the participation of an adult day health provider in the Medical Assistance Program. Only the program regulations, however, are transmitted by this letter.

These regulations supersede the "Standards for Adult Day Care under the Medical Assistance Program".

Please read the Preface for further details on the Provider Manual Series. The Department of Public Welfare hopes that this manual will be a convenient source of regulations, instructions, and general information.

These regulations are effective February 1, 1980.

NEW AND REVISED MATERIAL

Adult Day Health Manual, pages iv, vii, viii, and 4-1 through 4-21

4. PROGRAM REGULATIONS

Introduction 4-1
Definitions 4-1
Eligible Recipients 4-2
Provider Eligibility 4-3
Admission Procedures 4-4
Participant Care Plan 4-6
Program Services Requirements 4-7
Staffing Requirements 4-12
Staff Qualifications and Responsibilities 4-13
Participant Discharge and Referral 4-16
Outreach Requirements 4-17
Physical Plant 4-17
Recordkeeping and Reporting Requirements 4-20
Payment for Services 4-21

The regulations of the Department of Public Welfare governing provider participation in the Medical Assistance (Medicaid) Program are being published in a new format, the Provider Manual Series. This Adult Day Health Manual is the seventh of the new provider manuals. The Department intends to publish a separate manual for each provider type.

All provider manuals contain regulations that are incorporated into the Code of Massachusetts Regulations (CMR), a collection of regulations promulgated by state agencies within the Commonwealth and by the Secretary of State. Regulations promulgated by the Department of Public Welfare are assigned Title 106 of the Code. The regulations of the Medical Division are assigned Chapters 400 through 499 within Title 106.

Each manual in the series will contain administrative regulations, billing regulations, program regulations, applicable fee schedules, and general information.

Administrative regulations and billing regulations apply to providers in all provider types, and are designated 106 CMR Chapter 450.000. These regulations are reproduced as Subchapters 1, 2, and 3 in this Adult Day Health Manual.

Program regulations cover matters that apply specifically to providers in the provider type for which the manual was prepared. For adult day health providers, those matters are covered in Chapter 404.000 of Title 106, reproduced as Subchapter 4 in this Adult Day Health Manual.

The regulations in this manual appear as "sections", identified by three-digit numbers. The first digit of each number signifies the subchapter in which that section appears. The second and third digits signify the position of that section within the subchapter. At convenient intervals, section numbers have been reserved for the addition of revisions. Sections may be divided into the following components: subsections, which are designated by a capital letter in parentheses (e.g., (A)); divisions, which are designated by an Arabic numeral in parentheses (e.g., (1)); and subdivisions, which are designated by a lower-case letter in parentheses (e.g., (a)).

A citation to a section in this manual should include the CMR prefix. Thus, Section 101 of this manual should be cited 106 CMR 450.101, and Subsection (A)(1) of Section 405 of this manual should be cited 106 CMR 404.405(A)(1).

Fees and rates payable for services delivered under the Medical Assistance Program are adopted by the Massachusetts Rate Setting Commission (RSC). Each manual will contain reproductions of fee schedules (if any) applicable to the provider type for which the manual was prepared. Rates adopted by the RSC for specific providers will not be reproduced in the manuals.

In addition to administrative regulations, billing regulations, program regulations, and fee schedules, each manual will contain a variety of other materials useful to providers in the type for which the manual was prepared, such as statements or examples interpreting program regulations; copies of forms and instructions; and relevant addresses and telephone numbers.

Revisions and additions to the manual will be made as needed by means of transmittal letters, which furnish instructions for making changes by hand ("pen and ink" revisions), and by substituting, adding, or removing pages. Some transmittal letters will be directed to all providers; others will be addressed to providers in specific provider types. In this way, a provider will receive all those transmittal letters that affect its manual, but no others.

The Provider Manual Series is intended for the convenience of providers. Neither this nor any other manual can or should contain every federal and state law and regulation that might affect a provider's participation in the Medical Assistance Program. The provider manuals represent instead the Department's effort to give each provider a single convenient source for the essential information providers need in their routine interactions with the Department and Medical Assistance recipients.

Cite the sections on this page as 106 CMR 404.---

401 INTRODUCTION

In an effort to provide high-quality alternatives to institutional care, the Department has elected to pay for adult day health services under the Medical Assistance Program, subject to the conditions and limitations set forth in these regulations.

402 DEFINITIONS

The following definitions apply when used in these regulations.

(A) Adult -- any person aged 16 or older.

(B) Adult Day Health Services -- all services provided by adult day health programs approved for operation by the Department that meet the conditions set forth in the regulations in this Chapter 404.000 and whose general goal is to provide an alternative to 24-hour long-term institutional care through an organized program of health care and supervision, restorative services, and socialization.

(C) Attendance Day -- any day during which a participant attends the adult day health program for a minimum of six hours.

(D) Maintenance Therapy Services -- supplemental or follow-up physical, occupational, or speech therapy performed by adult day health program staff members under the direction of therapists, the program's registered nurse, or both.

(E) Occupational Therapist -- a qualified occupational therapist who is currently registered with the American Occupational Therapy Association.

(F) Physical Therapist -- a qualified physical therapist who is a graduate of a curriculum in physical therapy approved by the Council on Medical Education and Hospitals of the American Medical Association, who is currently registered by the Board of Registration and Discipline in Medicine under the laws of the Commonwealth of Massachusetts, and who has been certified by the U.S. Social Security Administration on or after October 30, 1970.

(G) Program Day -- any day during which the adult day health program is in operation.

(H) Restorative Services -- physical, occupational, and speech evaluation and therapy directly performed by a physical therapist, occupational therapist, or speech pathologist.

Cite the sections on this page as
106 CMR 404.---

402 DEFINITIONS (cont.)

(I) Site -- a single physical location of an adult day health program reviewed and approved by the Department and by other appropriate authorities for the operation of adult day health program services for a specified number of daily participants. If an adult day health provider operates an adult day health program in two separate locations, each location is considered to be a site. Each site must meet the regulations in this Chapter 404.000.

(J) Speech Pathologist -- a qualified speech pathologist who has been granted a Certificate of Clinical Competence by the American Speech and Hearing Association or who meets the equivalent educational requirements and work experience for such certification.

(K) Speech Therapist -- see "Speech Pathologist".

403 ELIGIBLE RECIPIENTS

(A) Medical Assistance Recipients

The Department pays for adult day health services provided to adult Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08) who meet the eligibility requirements below.

(1) A Medical Assistance recipient is eligible for enrollment as a participant in an adult day health program if:

(a) his medical condition indicates a need for nursing care, supervision, or therapeutic services that alone or in combination would normally require him to be institutionalized;

✓(b) his psychosocial condition is such that, without program intervention, his medical condition would continue to deteriorate, or he would be institutionalized; or

✓(c) his primary diagnosis is psychiatric in nature, but his condition is stable enough to allow him to participate in and benefit from the program. When a referred individual's needs for psychological services are beyond the capabilities of the program's staff members, the program must be assured, prior to the individual's admission, that he is receiving the necessary services from an appropriate resource.

Cite the sections on this page as 106 CMR 404.---

403 ELIGIBLE RECIPIENTS (cont.)

(2) A Medical Assistance recipient is not eligible for enrollment as a participant in an adult day health program if:

(a) his need for 24-hour care cannot be met in a six-hour structured day program combined with a community or family evening and weekend support system;

(b) his primary needs are social and may be met through a senior-center program or less-structured social-activity program;

(c) his behavior may be harmful to other program participants or staff members;

(d) his behavior may be very disruptive; or

(e) his primary diagnosis is psychiatric in nature and his condition is not stable enough to allow him to participate in and benefit from the program.

(3) The Department will not pay for adult day health services provided to a participant who is a Medical Assistance recipient, unless the recipient's participation has been approved by the Department in writing in accordance with Subsection 405(E).

(4) Adults referred to the program must be willing to attend the program a minimum of two full six-hour days per week, unless a special written agreement has been approved by the Department waiving this requirement.

(B) General Relief Recipients

The Department does not pay for adult day health services provided to General Relief recipients (category of assistance 04).

404 PROVIDER ELIGIBILITY

(A) In order to be eligible for Medical Assistance Program payment for adult day health services, a provider must:

(1) be enrolled as a participating provider in the Medical Assistance Program;

Cite the sections on this page as 106 CMR 404.---

404 PROVIDER ELIGIBILITY (cont.)

(2) meet the Massachusetts Department of Public Health Determination of Need requirements necessary for adult day health programs based in nursing homes or off-campus hospital-affiliated health centers and clinics; and

(3) meet the Massachusetts Department of Public Safety and local fire department requirements specified in Subsection 415(B).

(B) Groups or individuals that operate specialized day programs primarily for persons who are developmentally disabled, blind, deaf, or acutely mentally ill are not eligible to become adult day health providers.

(C) Adult day health programs operating outside of Massachusetts are not eligible to become adult day health providers.

405 ADMISSION PROCEDURES

(A) Physician's Documentation

Prior to an individual's first attendance day as a participant, the provider must obtain the following information from a physician, except when the Department provides a written waiver of this requirement in an emergency situation:

(1) the individual's medical history, which must indicate that a physical examination has taken place within the past three months. The physical examination should include a thorough examination of the condition of at least the following: temperature, pulse, reflexes, general appearance, weight, height, skin condition, eyes, ears, nose, throat, lips, teeth, tongue, mouth, gums, neck, lymph nodes, chest, heart, lungs, blood vessels, abdomen, genitalia, rectum, bones, joints, muscles, upper and lower extremities, breasts (female), and neurological system. If the individual has been hospitalized in the preceding three months, a complete discharge summary may be used to fulfill the physical examination requirement;

(2) a list of current medications and treatments;

(3) any special dietary requirements;

(4) a statement indicating any contraindications or limitations to the individual's participation in program activities; and

Cite the sections on this page as 106 CMR 404.---

405 ADMISSION PROCEDURES (cont.)

(5) recommendations for therapy, when applicable.

(B) Preadmission Interview

A preadmission interview must be conducted with the individual, and his family if applicable, by a professional member or members of the adult day health staff. The interview should provide the staff members with information on the general health characteristics, psychosocial condition, and nutritional habits of the individual; the nature of the individual's home or community support system; and any other relevant data pertaining to the individual or his situation. The interview should acquaint the individual and his family with the services, activities, and requirements of the adult day health program.

(C) Preadmission Interdisciplinary Team Assessment

An interdisciplinary team composed of the adult day health program's registered nurse and at least one other adult day health professional staff member must carefully assess the physician's documentation and the information obtained in the preadmission interview. If, in the professional judgment of the interdisciplinary team, the individual is appropriate for, and can benefit from, the adult day health program, the individual will be admitted to the program for a trial period of six weeks or until the provider receives notification of Department disapproval.

(D) Initial Admission Form

For each individual, the provider must complete an initial admission form furnished by the Department. This form must be completed on the individual's first attendance day and submitted to the Department.

(E) Assessment Form

For any individual who has attended the program for more than five attendance days or ten program days, the provider must complete a detailed assessment on a form furnished by the Department. This assessment must reflect the medical, functional, and psychosocial conditions or abilities of the individual. The provider must submit the assessment form to the Department within three weeks after the individual's first day of attendance. The Department shall evaluate the assessment and indicate to the provider, in writing, within the six-week trial period, its approval or disapproval of the individual's continued participation in the program. If the Department disapproves

Cite the sections on this page as
106 CMR 404.---

405 ADMISSION PROCEDURES (cont.)

the individual's participation in the program, the Department will not pay the provider for any services furnished to the individual more than ten days after the date of the written notice of disapproval. The Department will notify the provider by telephone immediately upon its decision to disapprove an individual's participation.

(F) Admission Agreement

Upon Department approval of an individual's participation in the program, the adult day health provider must conclude a written agreement with the individual and, if appropriate, with the individual's legal guardian. This agreement must specify the basic services offered to the individual by the provider, the cost of these services (see Section 422), and any nonfinancial obligations of the individual and his family to the program, such as a commitment from the individual to attend the program a specified number of days per week. The agreement must also specify the days and hours during which the program operates, a schedule of holidays when the program is closed, and the announcement procedures for unexpected closing of the program due to disaster or inclement weather.

406 PARTICIPANT CARE PLAN

(A) Within six program days after a participant's first attendance day, the adult day health program's staff members must complete a participant care plan for that individual. The program's registered nurse must coordinate the development of the participant care plan. The plan must include the following:

(1) a health treatment plan based on orders of the participant's physician, a nursing assessment, and, if applicable, recommendations of therapists for prescribed services; and

(2) a supportive-service and activity plan designed to meet the psychosocial and therapeutic needs of the participant.

(B) The provider must forward a copy of the participant's care plan to the participant's physician every three months and inform the physician of any subsequent change or lack of change in the participant's care plan. It is recommended that each participant receive an annual physical examination.

Cite the sections on this page as
106 CMR 404.——

406 PARTICIPANT CARE PLAN (cont.)

(C) The participant care plan must be written in a problem-oriented format designated by the Department. Adult day health program staff members must review the plan monthly (or more frequently if necessary) and must record in it any changes in the participant's treatment or condition. This plan must include monthly notes (or more frequent notes if the participant's condition so requires) in the participant's record written by the registered nurse and therapists involved in the care of the participant. In addition, the plan must include quarterly notes written by the activities director and social-service personnel. The plan must also indicate any other health or supportive services that the participant is receiving off site (e.g., homemaker, home health, visiting nurse, and therapy services).

(D) Department staff members shall make periodic on-site reviews to assess the quality of the participant's care plan and the participant's progress, and will be available to share ideas and procedures that may assist in improvement of the adult day health program.

407 PROGRAM SERVICES REQUIREMENTS

Providers must offer the services specified below in order to meet the needs of the participant population.

(A) Nursing Services

A registered nurse who is on site daily for a minimum of four hours must provide or supervise nursing services. If a nurse working within an institution is employed by the adult day health program, his sole responsibility during the hours that he is employed by the program will be to meet the needs of the adult day health participants. Nursing services must be provided in accordance with the particular needs of each participant and must include the following:

(1) supervision of the administration of medications and treatments as prescribed by the participant's physician;

(2) coordination of the development of the participant care plan;

(3) on-going monitoring of each participant's health status;

(4) maintenance-therapy treatment as recommended by a therapist; and

(5) coordination among the participant, his family, and program staff members of orders from the participant's physician.

Cite the sections on this page as 106 CMR 404.---

407 PROGRAM SERVICES REQUIREMENTS (cont.)

(B) Restorative Services

Adult day health programs must provide or coordinate restorative services as needed for each participant, when recommended by therapists and prescribed by a physician. Restorative services must include occupational, physical, and speech therapy. The provider must establish written agreements with individual physical, speech, and occupational therapists (unless they are employed as staff members), or must establish agreements for the services of such therapists with hospitals, clinics, or Visiting Nurse Associations, to provide consultant services to the program and, if necessary, to provide direct therapeutic services to a participant. Therapists must provide direct therapeutic treatment to a participant only if such treatment is referred by a participant's physician and cannot be administered by program staff members. The Department will pay the restorative-services provider for direct therapy administered to a participant on a fee-for-service basis in accordance with the Department's regulations governing restorative services.

(C) Maintenance-Therapy Services

Adult day health programs must provide maintenance therapy to meet the particular needs of each participant when indicated by the therapy consultants or the participant's physician. The program's registered nurse must supervise the administration of maintenance therapy to participants.

(D) Activities

Adult day health programs must provide individual and group activity programs that offer social, recreational, and educational events designed to improve each participant's self-awareness and level of functioning. The dignity, interests, and therapeutic needs of individual participants must be considered in the development of activity programs.

(E) Personal-Care Services

Adult day health programs, under the supervision of a registered nurse, must provide personal-care services as necessary, and must offer training and assistance in dressing, grooming, personal hygiene, use of special aids, accident prevention, and activities of daily living.

Cite the sections on this page as
106 CMR 404.---

407 PROGRAM SERVICES REQUIREMENTS (cont.)

(F) Nutrition Services

A hot meal, prepared under the direction of a dietitian, and two snacks must be provided to every participant each day he attends the program. The hot meal must be equivalent to at least one-third of the recommended daily dietary allowance established by the National Research Council. The provider must furnish special diets, if required by a participant and prescribed by his physician. In addition, program staff members, under the supervision of a registered nurse or dietitian, must provide nutrition counseling, consumer shopping advice, and menu planning to the participant and, if necessary, to his family.

(G) Counseling Services

A social worker, or other professional staff members if a social worker is not employed by the program, must provide individual and group counseling services to participants and their families. Counselors must offer assistance with personal, social, family, and adjustment problems. If specialized counseling is necessary for a participant or his family, the program must refer the participant or family to the appropriate community resource.

(H) Emergency Services

The provider must establish emergency procedures in writing. These procedures must include the following:

(1) a written letter of agreement with a nearby hospital for emergency care;

(2) a written letter of agreement with an ambulance company for emergency transportation (Emergency 911 may be substituted where available);

(3) an easily located file on each participant, listing the name and telephone number of the participant's physician, treatments or medications for a participant's special disabilities, and the name and telephone number of a family member, sponsor, or friend to be notified in case of emergency;

(4) a conspicuously posted notice indicating emergency fire procedures in accordance with local fire department regulations;

(5) training for program participants in emergency procedures, records of which must be kept on file; and

Cite the sections on this page as 106 CMR 404.---

407 PROGRAM SERVICES REQUIREMENTS (cont.)

(6) training for at least two professional staff members, as well as all drivers of program vehicles, in emergency procedures, cardiopulmonary resuscitation (CPR) (by an approved CPR instructor), and basic first aid. Records of completed training must be kept on file.

(I) Case Management

If a participant needs services from other community agencies, and if no agency has been determined as a coordinator of services for that participant, the adult day health provider must assume the role of coordinator to ensure that the participant's service needs are being met.

(J) Transportation Services

Program staff members must arrange for transportation services for participants. The provider must maximize the use of such low-cost or free community transportation services as FISH, senior shuttles, regional transit authorities, or free transportation provided by family, friends, or volunteers. The Department will pay providers for such low-cost community transportation services. Only after the provider has made every effort to secure low-cost transportation will the Department pay the provider for participants' traveling costs to and from the program by taxi, livery vehicles, or chair cars. For those providers that use their own vehicles, the Department will calculate a rate of payment. Providers must obtain a transportation provider number and must bill the Department directly for the actual approved cost of service per participant per mode of transportation. Chair cars and taxis used to transport participants must meet the requirements of the Department's transportation regulations. Program and livery vehicles must be clean and must meet all requirements established by the Massachusetts Registry of Motor Vehicles. It is the responsibility of the provider to do the following:

(1) arrange written agreements with each transportation provider used to meet the transportation needs of the participants. Copies of these agreements must be submitted to the Department;

(2) arrange to group up to four participants, when possible, in the same taxi or chair car, in order to keep the cost of such transportation low. In the case of group taxi transportation, the cost must be determined from the first point of pickup to the final destination. The cost will be divided equally among the number of participants transported;

Cite the sections on this page as 106 CMR 404.---

407 PROGRAM SERVICES REQUIREMENTS (cont.)

(3) keep accurate records, on a form supplied by the Department, that include the type of transportation used by each participant and the number of days he was transported to the program;

(4) keep accurate records of the cost of transportation services for each participant; and

(5) submit transportation records each month to the Department for review, to ensure that the least-costly appropriate transportation is being used.

(K) Hours of Operation

Adult day health programs must be open at least Monday through Friday for eight hours during the day. Participants must attend the program at least six hours each day, excluding transportation time to and from the program. For certain participants, under unusual circumstances, the Department may provide a written waiver of this requirement.

(408 through 410 Reserved)

Cite the sections on this page as 106 CMR 404.---

411 STAFFING REQUIREMENTS

(A) The provider must employ qualified individuals to furnish the required program services. There must be a minimum of two full-time professional staff members for each adult day health program. Additional personnel must be added to maintain a ratio of one full-time staff member involved in direct service to participants for each six participants. Secretaries, cooks, accountants, and other nondirect-care staff members must not be considered in calculating this one-to-six ratio. With written Department approval, a limited number of volunteers may be used to meet the staffing requirements.

(B) The qualifications and responsibilities of the required professional staff members and additional personnel are detailed in Section 412. The provider must meet the staffing requirements specified below.

(1) The provider must designate one of the full-time professional staff members as the program director. The program director is responsible for the activities outlined in Subsection 412(A).

(2) The provider must designate one of the professional staff members as assistant program director to act in the absence of the program director.

(3) The provider must employ a registered nurse who will be on the site daily for a minimum of four scheduled hours. If the program's daily enrollment is 18 or more participants, the provider must employ a registered nurse who will be on site daily for eight hours a day, or a registered nurse and a licensed practical nurse who will each be on site daily for a minimum of four hours. Such hours must be arranged to ensure full-day nursing coverage. Backup coverage must be arranged for the registered nurse in the event of his absence due to illness or vacation.

(4) The provider must employ an activities director who will be on site daily for a minimum of four scheduled hours.

(5) If the program's daily enrollment is 24 or more participants, the provider must employ a social worker who will be on site for a minimum of 20 scheduled hours each week.

(C) To meet the one-to-six ratio, the provider must employ additional staff members from a variety of fields. Such staff members must be carefully selected for their ability to provide the required program services and to meet the direct-care needs of the participants.

Cite the sections on this page as
106 CMR 404.---

412 STAFF QUALIFICATIONS AND RESPONSIBILITIES

(A) Program Director

The program director must be chosen carefully from among the professional staff members for his ability to assume an administrative leadership role. It is the responsibility of the program director to do the following:

(1) direct and supervise all aspects of the program;

(2) supervise all paid and voluntary staff members;

(3) perform program and staff-member evaluations;

(4) assume the role of coordinator in the admission process;

(5) respond to the reporting requirements of the Department set forth in Section 421;

(6) direct the development and implementation of the program's outreach plan;

(7) be responsible for the fiscal administration of the adult day health program, including billing, budget preparation, and required financial reports; and

(8) direct the coordination of transportation services.

(B) Registered Nurse

The registered nurse must be licensed by the Board of Registration in Nursing to practice in the Commonwealth of Massachusetts. The nurse must have at least two years' recent experience in the direct care of elderly or chronically disabled persons. It is the responsibility of the registered nurse to do the following:

(1) provide or supervise required program nursing services to each participant;

(2) supervise other health-care staff members;

(3) coordinate the development and on-going review of the participant care plans;

Cite the sections on this page as
106 CMR 404.---

412 STAFF QUALIFICATIONS AND RESPONSIBILITIES (cont.)

(4) write, at least monthly, nursing notes in the participant's record or delegate this task to a licensed practical nurse; and

(5) assist as necessary in the delivery of other required program services.

(C) Licensed Practical Nurse

The licensed practical nurse must be licensed by the Board of Registration in Nursing to practice in the Commonwealth of Massachusetts. It is the responsibility of the licensed practical nurse to do the following:

(1) provide nursing services to each participant under the supervision of the program's registered nurse;

(2) if so delegated by the registered nurse, write, at least monthly, nursing notes in the participant's record; and

(3) assist as necessary in the delivery of other required program services.

(D) Activities Director

The activities director must have one or more years' experience working in an adult social or recreational program. The activities director must have the ability to develop and to implement therapeutic activity programming both for specific individuals and for groups. The Department may waive the experience requirement for exceptionally qualified individuals. It is the responsibility of the activities director to do the following:

(1) develop, in conjunction with the occupational therapy consultant, activity programs that meet the individual needs of each participant;

(2) supervise activity program assistants;

(3) schedule educational events;

(4) write, at least quarterly, notes in the participant's record regarding the participant's involvement in activities as part of his care plan;

(5) participate in the monthly review of each participant's care plan; and

Cite the sections on this page as
106 CMR 404.---

412 STAFF QUALIFICATIONS AND RESPONSIBILITIES (cont.)

(6) assist as necessary in the delivery of other required program services.

(E) Social Worker

The social worker must have at a minimum a bachelor's degree in human services from an accredited college or university and at least one year's recent experience working with adults in a professional capacity. The Department may waive the experience requirement for exceptionally qualified individuals. It is the responsibility of the social worker to do the following:

(1) coordinate and provide individual, group, and family counseling;

(2) inform participants and their families of available community services and refer participants as necessary to agencies providing such services;

(3) write, at least quarterly, notes in the participant's records; and

(4) assist as necessary in the delivery of other required program services.

(F) Aide

The aide must have one or more years' experience working with adults in a health-care or social-service setting. The aide is responsible for assisting professional program staff members as required in implementing the program services and meeting the needs of individual participants. The Department may waive the experience requirement for exceptionally qualified individuals.

(G) Driver

If the program operates its own vehicle, the driver must possess a valid Massachusetts driver's license and be fully instructed in the motor-vehicle laws of the state. The driver must have experience in transporting passengers and must be sensitive to the needs of aged or handicapped persons.

Cite the sections on this page as 106 CMR 404.---

412 STAFF QUALIFICATIONS AND RESPONSIBILITIES (cont.)

✓ (H) Consulting Therapists

The qualifications of therapists are specified in the Department's restorative services regulations. The responsibility of the occupational and physical therapy consultants is to confer for at least one hour a month with program staff members to improve or to develop therapeutic programming or to provide group therapy-education classes for participants. Speech therapy consultants must be available as necessary to consult with program staff members. Consultation time must be documented in program records.

413 PARTICIPANT DISCHARGE AND REFERRAL

(A) A participant shall be discharged from the program under the following circumstances:

(1) he demonstrates sufficient improvement to enable him to live more independently;

(2) he requires specialized institutional care, due to illness;

(3) he develops behavioral problems that may endanger or seriously disrupt other participants or staff members; or

(4) he wishes to discontinue participation in the program.

(B) The provider must establish, in writing, and implement the following procedures for discharge and referral:

(1) a discharge summary;

(2) postdischarge goals;

(3) recommendations for sources of continuing care (e.g., Home Care Corporations or home health agencies); and

(4) referral to community service agencies for appropriate services, if the participant is returning to a more independent living situation.

Cite the sections on this page as
106 CMR 404.---

413 PARTICIPANT DISCHARGE AND REFERRAL (cont.)

(C) The provider must submit to the Department a discharge form furnished by the Department indicating a discharge plan for each participant leaving the program. The provider must discuss and agree upon the discharge plan with the participant and his family as far in advance of discharge as possible. This form must be submitted to the Department within one week after discharge.

414 OUTREACH REQUIREMENTS

The provider must establish an outreach plan designed to reach the appropriate population and to inform the community at large of the program's services. The plan must be implemented as needed and must include the following:

(A) a program brochure;

(B) letters to physicians, health facilities, and social-service agencies in the area, informing them of the program and its services;

(C) meetings with community service agencies and community leaders to develop referral mechanisms. The provider must contact, at the minimum, Home Care Corporations, Visiting Nurse Associations, hospital social-service departments, and hospital discharge planners;

(D) notices in community facilities;

(E) an open house for the general public and community groups; and

(F) at least one article or advertisement in a local newspaper each year.

415 PHYSICAL PLANT

(A) An adult day health program site must be located in an environment that is free of architectural barriers and is designed to meet the specialized needs of handicapped persons.

(1) Curb cuts, gradients, handrails, steps, and ramps must be designed or adapted to offer easy accessibility to the site by the specialized population being served.

Cite the sections on this page as 106 CMR 404.---

415 PHYSICAL PLANT (cont.)

(2) The site must be designed or adapted to provide adequate turning space for wheelchairs. Light switches, control panels, counters, sinks, and door handles must be within easy reach of a wheelchair-bound person. Door frames must be wide enough for easy entering and exiting of wheelchairs, and thresholds must be eliminated.

(3) There must be at least two toilet facilities at each site. One of these facilities must be designed or adapted to provide access and maneuverability for handicapped or wheelchair-bound individuals. The toilet areas must be equipped with grab bars or siderails.

(4) The site must be designed to ensure the health, safety, and comfort of participants and staff.

(5) The site must be designed with adequate space for the provision of required services. Each site must include the following:

(a) a dining area;

(b) a food-preparation area equipped with a refrigerator, a sink, and adequate counter and storage space;

(c) a project area equipped with adequate table and seating space (a dining area may be used);

(d) a group-activity area;

(e) a private enclosed space, free from disruption, for individual nursing services or counseling; and

(f) a rest area equipped with at least one comfortable resting chair for every six participants per day.

(B) The provider must obtain certification from the Massachusetts Department of Public Safety and from its local fire department approving the area for program operation. Such certification must indicate the maximum daily participant occupancy. The provider must also, if necessary, obtain certification from its local zoning board. The provider must submit such certifications to the Department prior to the start of program operations.

Cite the sections on this page as
106 CMR 404.---

415 PHYSICAL PLANT (cont.)

(C) Providers must have on site at least the following health-care equipment: an emergency first-aid kit, a scale, a blood-pressure cuff, a foot basin, a thermometer, a locked storage space for drugs, refrigeration for drugs, and a blanket.

(D) The provider must have an easily accessible fire extinguisher.

(E) The Department shall set a limit on the maximum daily participant capacity for the space designated. The maximum capacity limit may be increased only with the written permission of the Department. A minimum of 50 square feet of space must be available for each participant, excluding office, toilet, hallway, and other areas not used for the provision of adult day health services.

(416 through 420 Reserved)

Cite the sections on this page as
106 CMR 404.---

421 RECORDKEEPING AND REPORTING REQUIREMENTS

(A) The provider must keep all records pertaining to billing, finances, program, personnel, and individual participants for at least four years after the date of service.

(B) The provider must maintain accurate and up-to-date financial records. These records must include at least the following information:

(1) sources of gross monthly program income; and

(2) monthly program expenses (personnel costs, rent or building-use costs, consumable supplies, purchase or rental of equipment, utilities, insurance, repairs, maintenance, license fees, transportation costs, and administrative and professional services). Direct costs and in-kind contributions or services must be recorded separately.

(C) The provider must maintain detailed records of the number of participants being served, the number of individuals waiting for admission to the program, and the number of personnel and their qualifications.

(D) The provider must maintain other records as may be required by the Department and as specified in these regulations or in the contract agreement between the provider and the Department.

(E) The provider must make all records available to the Department as needed for evaluation and review.

(F) The adult day health program director or his designee must be responsible for notifying the Department immediately in writing in the following situations:

(1) fire, accident, injury, or evidence of serious communicable disease contracted by staff members or participants;

(2) death of a participant at, en route to, or en route from the program; and

(3) changes in professional personnel

(G) The provider must obtain written approval from the Department before relocating a program site or adding a new program site.

Cite the sections on this page as
106 CMR 404.---

421 RECORDKEEPING AND REPORTING REQUIREMENTS (cont.)

(H) The provider must notify the Department at least 60 days in advance of terminating the program.

(I) The provider must obtain written approval from the Department before increasing the number of daily participants in the program.

422 PAYMENT FOR SERVICES

(A) The Massachusetts Rate Setting Commission determines the maximum allowable fee for adult day health services. The maximum allowable payment for a service shall be the lower of the following:

(1) the adult day health program's usual and customary fee (if a sliding fee scale is used, the highest dollar amount of the scale shall be considered to be the usual and customary fee); or

(2) the amount that the Rate Setting Commission has established for that service.

(B) The Department will pay the provider for only the sessions actually attended by a participant who is a Medical Assistance recipient.

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